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STUDII

INTERVIU - INTERVIEW

RECENZIE – BOOK REVIEW

STUDIA UBB BIOETHICA, LX, 2, 2015 (p.5-7)
(RECOMMENDED CITATION)

EDITORIAL:

BIOETHICS AT THE INTERSECTION OF A COMPLEX NEW REALITY

Assist. Prof. MARIA ALUAȘ PhD

Bioethics is a broadly interdisciplinary field of inquiry concerning the application of the biomedical sciences to health and life, at the intersection of several disciplines, such as medicine, biology, ethics, philosophy, theology and law. But even sociology, psychology, or psychoanalysis are also involved.

In 1970, the American oncologist Van Rensselaer Potter, in the article entitled *Bioethics, the science of survival*, resumed a year later, in his book, *Bioethics: bridge to the future*, ascertained an extraordinary development of the scientific knowledge, especially those of biology, on the one hand, and on the other, a delay of the theoretical thinking necessary for the use of these ones, thus proposing a new science – the science of survival – based on the alliance between biological knowledge („bio") and the one of the human values („ethics"). The domain of bioethics, according to Potter, had to include all the relative dimensions to the survival of the human species and the planet, like: the control of the population, peace, poverty, ecology, animal life, the welfare of the humanity etc.

According to N. Lenoir and B. Mathieu, „bioethics refers to the rules of behavior which a society establishes for itself in order to face the difficulties or the dilemmas born out of the progress of life's sciences"[1]. The Oviedo Convention of the Council of Europe named *The Convention Regarding Human Rights and Biomedicine* (4th of April 1997), offers bioethics a definition, associating with it the human rights: „the protection of human rights and the

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[1] N. Lenoir, B, Mathieu, *Les normes internationales de la bioethique*, PUF, coll. „Que sais-je?", no. 3356, 1998.

dignity of the human being against the new applications of biology and medicine"[2].

At present, Bioethics topics concern medical and research activities who use the elements of the human body. For exemple: organs swab, tissue, bone marrow; medical assistance to procreation, referring to egg and sperm donation; the embryo and embryonic cells research; and the detection of genetic diseases.

As stakes, Bioethics wants to answer in a better way to the issues of scientifical and technical progress, concerning our society(s) values and to ensure respect for human dignity and protection for the most vulnerables from all forms of exploitation.

This issue of our publication gives you a brief overview of how bioethical reflexion in the medical research area, including even some analyses of cases in the Eastern Europe countries. Also, papers present medical or technological advances that have influenced current debate, and mention of particularly significant bioethics writings in the area. From history of medicine end research methodology to animal protection and welfare, studies involve ethical issues in drug prescribing practices, ethical approaches in research practice, ethical aspects of using biospecimens in research, ethical issues in research, but also the meanings of the concept of person and two papers on Rroma populations issues in some countries in Eastern Europe.

The characteristic of the current issue is the following one: the most of part of authors are involved in the Fogarty International Program in Research Ethics Education in the Balkans and Black Sea Countries, a program for researchers in the Balkans and Black Sea countries, financed by the US government. The project combines the resources of the Icahn School of Medicine at Mount Sinai (New Yourk, US) and regional institutions to advance the development of research ethics and infrastructure in South-Eastern Europe. The educational program is for clinicians, biomedical researchers, and other professionals from the region. The syllabus of the program is designed to develop expertise in research ethics. During classes and modules, students are involved in debates, cases analyse, discussion and interaction on topics

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[2] *The Convention Regarding Human Rights and Biomedicine* (4th of April 1997), http://conventions.coe.int/Treaty/en/Treaties/Html/164.htm, last accessed 25 th April 2013.

like: history of research ethics and critical assessment of codes; methods of research; responsible conduct of research; the ethics of science; introduction to the ethics of medicine; basic concepts in research ethics; populations and regulations in research ethics; the ethics of international and public health research; teaching research ethics; the organization and conduct of an institutional review board.

Topics are new and interesting for students in Eastern Europe countries, because they did not followed a very systematic program in biomedical ethics, in research ethics, or medical ethics. Being involved for over 2 years in this program they could learn, understand, assess, communicate and share their opinions, solutions and propositions of this new and challenging area of research.

STUDII

STUDIA UBB BIOETHICA, LX, 2, 2015 (p.11-20)
(RECOMMENDED CITATION)

ETHICAL ISSUES IN DRUG PRESCRIBING PRACTICES IN ROMANIA. OPINIONS OF THE PHARMACEUTICAL REPRESENTATIVES

MAGDALENA IORGA[1], LASZLO-ZOLTAN SZTANKOVSZKY[2]*, CAMELIA SOPONARU[3], BEATRICE-GABRIELA IOAN[4]

REZUMAT. Probleme etice în practicile prescrierii medicamentelor în România. Opinii ale reprezentanților farmaceutici. Studiul are ca scop identificarea opiniilor reprezentanților farmaceutici cu privire la practicile prescrierii medicamentelor de către medici în România. *Material și metodă*: un număr de 70 de reprezentanți farmaceutici care lucrează la diferite companii farmaceutice din România au răspuns la un chestionar privind practicile de prescriere a medicamentelor de către medici. Variabilele ca vârstă, sex, educație medical/non-medicală, experiența de lucru sau mediul de lucru au fost luate în considerație. Datele culese au fost prelucrate cu Statistical Package for Social Sciences (SPSS) versiunea 17.0 pentru Windows. *Rezultate*: 95% dintre subiecți apreciază că medicii își folosesc experiența cu un anumit medicament atunci când îl prescriu. Un număr de 67% dintre reprezentanții farmaceutici consideră că medicii își acoperă costurile activităților legate de educația medicală continuă și training prin sponsorizări oferite de către companiile farmaceutice. 66% dintre participanți apreciază că relațiile medicilor cu reprezentanții medicali sunt importante atunci când prescriu medicamente. *Concluzii*: Reprezentanții farmaceutici consideră că practicile de prescriere a medicamentelor de către medici sunt influențate de mai mulți factori legați de politicile de sănătate sau criterii personale, inclusiv relațiile dintre medici și reprezentanții farmaceutici.

***Cuvinte-cheie**: etică, reprezentant farmaceutic, prescrierea de medicamente, medic.*

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[1] *PhD lecturer, psychologist, Department of Behavioral Sciences, "Gr. T. Popa" University of Medicine and Pharmacy, Iasi, Romania, email: magdalena.iorga@umfiasi.ro*

[2] *PhD student, MD, Department of Behavioral Sciences, "Gr. T. Popa" University of Medicine and Pharmacy, Iasi, Romania*

** Corresponding Author: sztankovszky@yahoo.com*

[3] *PhD, psychologist, associated professor, "Al. I. Cuza" University of Iasi, Romania, email: puzdriac@yahoo.com*

[4] *PhD, MD, associated professor, "Gr.T.Popa" University of Medicine and Pharmacy, Iasi, Romania, email: ioanbml@yahoo.com*

ABSTRACT. The study aims at identifying the opinion of pharmaceutical representatives about drug prescribing practices by physicians in Romania. *Material and methods:* a number of 70 pharmaceutical representatives working with different pharmaceutical companies in Romania answered a questionnaire concerning drug prescribing practices by physicians. Variables like age, medical/nonmedical education, and work experience or work environment were taken into consideration. Data were processed by Statistical Package for Social Sciences (SPSS) version 17.0 for Windows. *Results*: 95% of the subjects appreciate that physicians use their experience with a particular drug when they prescribing it. A total of 67% of pharmaceutical representatives think that physicians cover the costs of activities related to their continuing education and training by sponsorships offered by the pharmaceutical companies. 66% of the participants claim that the physician's relationship with the medical representative is important when prescribing drugs. *Conclusion*: the pharmaceutical representatives are considering that drug prescribing practices by physicians are influenced by several factors, related to health policies or personal criteria, including the relationship between the physician and the pharmaceutical representative.

Keywords*: ethics, pharmaceutical representative, drug prescription, physician.*

1. Introduction

The interactions between the physicians and the pharmaceutical representatives were largely detailed in the scientific literature in order to identify to what extent the relationship between them influence the drug prescribing process.

The interaction begins in the medical school and continues with a rate of 4, 4 meetings per month (Wazana, 2000) but recent studies show that this rate is even higher (Campbell, 2007 a b). Other studies show that 80-95% of physicians meet pharmaceutical representatives regularly and the increase in prescribing a drug can be observed in the next 6 months after attending a sponsored conference. It is also estimated that, in United States, for examples, approximately 21.000 dollars are spent yearly by the pharmaceutical companies for each physician (Breen, 2004).

Despite the fact that physicians declare that they are not influenced by their relationship with the pharmaceutical representatives, or that this interaction can influence to a little extent their objectivity when prescribing drugs (Chimonas, 2007), the tools used by the pharmaceutical representatives are being declared as accepted and appreciated (gifts, financial support for the continuing educations, touristic packages, sponsorships for the employing institution, invited speaker, samples or participation in clinical trials) and the analysis of the physicians' behaviour is proving that prescribing costs are increasing (Caudill et al, 1996).

Many studies showed that the physician-pharmaceutical representative relationship influence the drug prescribing process. Previous studies identified that patient's prescription is finally the result of physician-pharmacist-pharmaceutical representative interaction (Iorga et al, 2015; Sztankovszky et al, 2015, a2015b, 2015c). However professional behaviour must be guided by education and policy rules.

The goal of our study was to identify the opinions of the pharmaceutical representatives about drug prescribing practices by physicians in Romania and to appreciate in what extent they use different tools to promote their products to physicians.

2. Material and Methods

A number of 70 pharmaceutical representatives working for different pharmaceutical companies and located in 14 county seats in Romania agreed to participate in the survey. The work area covers approximately 75% of the country, taking into account that each pharmaceutical representative may conduct business in a maximum of 4 counties. The survey was conducted between January and May 2015.

The printed questionnaires were accompanied by the informed consent paper, explaining to the participants the purpose of the survey, guaranteeing confidentiality of personal data and the method for dissemination of study results. The option not to take part in the study was granted to all subjects. The research was approved by the Research Ethics Committee of the "Gr. T. Popa" University of Medicine and Pharmacy in Iași and it is a part of a larger research having the objective to identify the opinion of pharmaceutical representatives about practices of promoting, prescribing and dispensing drugs in Romania.

The questionnaire was designed to identify the opinion of pharmaceutical representatives about the drug prescribing practices in Romania and it covers 7 dimensions detailed below.

Dimension 1- Criteria used by physicians when prescribing treatment: Item 1: personal experience with a certain molecule, Item 2: clinical observations throughout their professional path, practical results, Item 3: meta-analyses related to the given drug, published in meaningful journals, Item 4: the innovative character of the given drug, recent scientific information, Item 5: the standard treatment protocol for the given diagnosis.

Dimension 2- Means by which physicians cover the costs of their continuing education and training: Item 1: sponsorships from the pharmaceutical industry, Item 2: sponsorships from the employing institution, Item 3: sponsorships from national and international projects and grants, Item 4: financial self-support (personal resources).

Dimension 3- The influence of health policies and the patient's possibilities of financial contribution on drug prescribing: Item 1: the patient's financial contribution, Item 2: budgetary limitations imposed by the National Health Insurance House, Item 3: availability of the drug in local pharmacies.

Dimension 4- The physician's relationship with the pharmaceutical representative.

Dimension 5- Complementing the treatment of the given pathology with over-the-counter (OTC) products and supplements.

Dimension 6- Using international non-proprietary names (INNs) when prescribing drugs.

Dimension 7- Recommending the brand name product along with the INN.

The items were multiple choice, with answer options on a scale of 1 to 4, where 1 – *never*, 2 – *sometimes*, 3 – *often*, 4 – *always*.

The collected data were processed by means of the statistical processing software SPSS (Statistical Package for Social Sciences) version 17.0 for Windows.

The following types of statistical methods were used:

- Descriptive statistics, which pursued the central tendency and dispersion indicators (the mean and standard deviation).
- Comparative statistics- the Mann-Whitney test for nonparametric data, for independent samples was used due to the testing of the difference between independent groups of pharmacists, for which the dependent variable was expressed in ordinal (ranking) values.
- Correlational study, aimed at identifying the various correlations between independent and dependent variables, by calculating Spearman's correlation coefficient (correlations being significant at an accepted significance threshold $p < 0.05$). Spearman's coefficient is used because nonparametric data is involved.

The independent variables (age, duration of employment, gender, category, medical/nonmedical university education) influence the dependent variables taken into account: the collaborative relationship with the physician (using informal gifts- flowers, chocolate; samples; sponsorship for physicians for the purpose of continuing medical education or for the medical institutions, other informal sponsorships; participations in clinical studies, market research and observational studies).

The age of the participants was in the range 25-48 years, with an M of 35.44 ± 5.89 years.

The share of female and male pharmaceutical representatives was balanced: 34 participants (48.57%) were male (age M= 37.20 ± 5.81) and 36, representing 51.43%, were female (age M = 33.77 ± 5.54). Work experience ranges from 1 to 27 years, with M = 11.60 ± 5.76.The minimum length of employment as a pharmaceutical representative declared was 1 year and the maximum was 18 years, with M = 8.02 ± 4.56. There are no major differences in the length of employment variable between genders.

A total of 56 pharmaceutical representatives (80% of the participants) work in urban environments, 5 participants (7.14%) work in rural environments and 9 participants (12.86%) carry out the promotion of products of their employing companies both in urban and in rural environments.

Of the 70 pharmaceutical representatives included in this study, 41 (58.57%) have medical studies (General Medicine or Pharmacy) and 39 subjects (41.43%) graduated from non-medical faculties.

A number of 28 men (40%) and 28 women (40%) work as pharmaceutical representatives in urban environments; 1 man (1.43%) and 4 women (5.71%) work in rural environments; the subjects who carry out their professional activity both in rural and in urban areas are 5 men, representing 7.14%, and 4 women (5.71%).

3. Results and Discussions

The pharmaceutical representatives have answered seven questions concerning drug prescribing practices by physicians and other aspects related to their activity.

1. The analysis of the answers to the question: *How frequently do you consider that the physician applies the following criteria in prescribing treatment* showed that:

a. Experience with a particular molecule: 2.9% (N = 2) never, 1.4% (N = 1) rarely, 51.4% (N = 36) often, 44.3% (N = 31) always, with a mean value of M = 3.37 ± 0.66.

b. Clinical observations throughout the career path and practical results: 1.4% (N = 1) never, 10% (N = 7) rarely, 58.6% (N = 41) often, 44.3% (N = 31) always, with M = 3.17 ± 0.65.

c. Meta-analyses related to the given treatment, published in scientific journals: 8.6% (N = 6) never, 47.1% (N = 33) rarely, 32.9% (N = 23) often, 11.4% (N = 8) always, with M = 2.47 ± 0.81.

d. Scientific information/reading about the latest research in the given field: 12.9% (N = 9) never, 37.1% (N = 26) rarely, 34.3% (N = 24) often, 15.7% (N = 11) always, with M = 2.52 ± 0.91.

e. The standard treatment protocol for the given diagnosis: 5.7% (N = 4) never, 14.3% (N = 10) rarely, 51.4% (N = 36) often, 28.6% (N = 20) always, with M = 3.02 ± 0.81.

Pharmaceutical representatives believe that, in 95% of cases, physicians apply their experience with a particular drug as a prescribing criteria.

From the analysis of results, we identify the fact that, according to pharmaceutical representatives, 78% of physicians primarily take into account the standard treatment protocol for a given diagnosis. In order of importance, we identify the experience with a particular molecule, the standard treatment protocol, clinical observations, information obtained from recent research and, lastly, meta-analyses published in scientific journals.

2. To the question which aims to identify the pharmaceutical representative's opinion regarding *ways in which the physicians pay the costs of their continuing education and training*, the participants answered the following:

a. By sponsorships from the pharmaceutical industry: 14.29% (N = 10) of the participants consider that the physicians never pay for their continuing education by sponsorships from the pharmaceutical industry, 18.57% (N = 13) think that this rarely happens, 48.57% (N = 34) consider that this often happens and 18.57% (N = 13) consider that physicians always pay the costs of their continuing education by sponsorships from the pharmaceutical industry (M = 2.71 ± 0.93).

b. By sponsorships from the employing institution, with M = 2.02 ± 0.90, a percentage of 32.86% (N = 23) of pharmaceutical representatives think that physicians never pay the costs of their continuing education by sponsorships from the employing company, 37.14% (N = 26) claim they rarely do so, 24.29% (N = 17) often, 5.71% (N = 4) claim that physicians always pay the costs of their continuing education by sponsorships from the employing company.

c. By sponsorships from grants or national/international projects, with M = 2.24 ± 0.90, a percentage of 20% (N = 14) of pharmaceutical representatives believe that physicians never pay the costs of their continuing education by financial resources obtained through projects or grants, 47.14% (N = 33) claim that they rarely do so, 21.43% (N = 15) believe they often do so and 11.43% (N = 8) claim that physicians always pay the costs of their continuing education and training by sponsoring from national or international projects and grants.

d. Paying the costs of continuing education and training from personal financial resources, with M = 2.67 ± 0.97, a percentage of 12.86% (N = 9) of pharmaceutical representatives estimate that physicians never pay the costs of their continuing education by personal resources, 30% (N = 21) claim they rarely do so, 34.29% (N = 24) declare they often do so and 22.86% (N = 16) of pharmaceutical company representatives believe that physicians always pay the costs of their continuing education from personal financial resources. A total of 67% of pharmaceutical representatives think that physicians pay the costs of activities related to their continuing education and training by sponsorships from pharmaceutical companies.

Aproximatly56% estimate that physicians frequently pay for their participation in courses and trainings from personal funds, while the other sources are, to a lesser extent, funds obtained from national or international projects and grants and assistance from the employing institution.

Thus, in the opinion of pharmaceutical representatives, physicians pay for their continuing education and training by the following means, in the decreasing order frequency: sponsorships from pharmaceutical companies, personal financial resources, financial resources from national/international projects/grants, sponsorships from the employing institution

3. The third question followed pharmaceutical representatives' opinion of physicians' treatment prescribing practices, assessing to what extent the physician takes into account the patient's financial contribution (M = 2.90 ± 0.81) when establishing the treatment, to what extent the physician takes into account the budgetary limitations by the *National Health Insurance House* (*NHIH*) with M = 3.08 ± 0.79, or the availability of the prescribed drug in the local pharmacies (M = 2.68 ± 0.97). The distribution of pharmacists' answers to this question is detailed in the table below:

When prescribing treatment, the physician takes into account:	Never N (%)	Rarely N (%)	Often N (%)	Always N (%)
The patient's financial contribution	6 (8.57%)	9 (12.86%)	41 (58.57%)	14 (20%)
Budgetary limitations of the National Health Insurance House	2 (2.88%)	13 (18.57%)	32 (45.71%)	23 (32.88%)
Drug availability in local pharmacies	8 (11.43%)	23 (32.88%)	22 (31.45%)	17 (24.29%)

The data in the table above show that the pharmaceutical representatives consider that when prescribing a drug the physicians take into account (in the decreasing order of frequency): the budgetary limitations of the National Health Insurance House, the patient's financial contribution, the availability of a drug in local pharmacies.

4. Concerning the question *When prescribing a particular drug, is the physician's relationship with the pharmaceutical representative important?*, the participants' answers (M = 3.04 ± 0.84) are the following: 5 of them (7.14%) consider that the physician's relationship with the pharmaceutical company representative is never important, 9 participants (11.43%) claim that this is rarely important when prescribing a drug, 36 participants (51.43%) appreciate that the relationship between the physician and the pharmaceutical representative is often important and 21 of them (30%) consider that this relationship is always important when prescribing a drug. 66% of the participants consider that the physician's relationship with the medical representative is important when prescribing drugs.

5. To the question concerning *the physician's practices of recommending over-the-counter (OTC) products and supplements in addition to the treatment of the given pathology*, the average of answers is 2.77 ± 0.59. 22 participants (31.43%) estimate that physicians rarely recommend these products, while most of the participants- 42 (60%)-consider that the physicians often do so and 6 (8.57%) always supplement the established medication for the given diagnosis with additional products – OTC and supplements.

In pharmaceutical representatives' opinion, over 60% of physicians often recommend over-the counter products and supplements to complement a patient's recommended treatment.

6. Concerning the question aimed at the participants' opinions about *physician's use of international non-proprietary names (INNs) in prescriptions*, 2 pharmaceutical representatives (2.86%) think that physicians rarely do this, 45 (64.29%) think they often prescribe INN and 23 (32.86%) claim that physicians always prescribe INN subjects (M = 3.30 ± 0.52).The results show that 96% of the participants consider that physicians prescribe INNs.

7. The seventh question aims at identifying pharmaceutical representatives' opinion regarding *physicians' practices of prescribing INNs, but also recommending the brand name product.* The statistical analysis of the answers (M = 2.91 ± 0.67) highlighted the fact that 2 (2.86%) pharmaceutical representatives estimate that physicians do not recommend the brand name product as well when prescribing treatment, 13 (18.57%) consider that physicians rarely recommend the brand name product too, 44 (62.86%) mention that physicians often provide this additional information and 11 (15.7%) of them consider that physicians always recommend the brand name product too. According to pharmaceutical representatives, 60% of physicians recommend the brand name product as well when prescribing treatment.

4. Conclusions

Our study showed that according to the opinions of the pharmaceutical representatives, physicians use mainly their experience with a particular drug as prescribing criteria. Nonetheless physicians pay for the activities related to their continuing education and training by sponsorships from pharmaceutical companies and the relationship between the physicians and pharmaceutical representatives is important to the drug prescribing practices. Many physicians often recommend *over-the counter* products and supplements to complement a patient's recommended treatment and the majority of pharmaceutical representatives consider that physicians write prescriptions with international non-proprietary names. Also the participants consider that more than a half of the physicians recommend the brand name product as well when prescribing treatment.

Our findings prove that prescribing drug is a process influenced by a many factors, among them we can name physician-pharmaceutical representative relationship, personal experience with a drug, the health policies related to the patients' financial possibilities. The research proves that prescribing drug practices in Romania is not entirely objective and that the official rules must be taken into consideration when dilemmatic situations occur.

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AVICENNA'S CANON OF MEDICINE. RESEARCH METHODOLOGY AND ETHICS

SORIN HOSTIUC[1]*, IONUT NEGOI[2], OCTAVIAN BUDA[3], ALIN MOLDOVEANU[4], MIHAELA HOSTIUC[5]

REZUMAT. ***Canonul Medicinei*** **de Avicenna. Metodologia și etica cercetării.** Avicenna a fost unul dintre cei mai importanți medici și filosofi din Islam. El a scris peste 100 de tratate de medicină, unele dintre ele conținând doar câteva pagini. Lucrarea sa majoră, intitulată „Canonul Medicinii", a fost încheiată în anul 1025 și a inclus cinci volume. Cel de-al doilea volum al Canonului începe cu o serie de condiții generale pe care testarea de noi medicamente ar trebui să le îndeplinească, pe care le-a detaliat în capitolul intitulat „Despre cunoașterea potenței medicamentelor prin experimentare." Aceste recomandări sunt analizate în prezentul articol prin corelare cu actualele principii de etică a cercetării și de metodologie.

Cuvinte-cheie: *Avicenna, etica cercetării, metodologia cercetării*

ABSTRACT. Avicenna was one of the most important Islamic physicians and philosophers. He wrote over 100 treaties of medicine, some of them containing only a few pages. His major medical work, entitled "The Canon of Medicine", was finished in 1025, and included five volumes. The beginning of the Volume 2 of the Canon started with a series of general preconditions that the testing new medicines should fulfil, detailed in the chapter entitled "On knowledge of the potency of drugs through experimentation". These recommendations will be analysed in this article in correlation with current principles of research ethics and methodology.

Keywords: *Avicenna, research ethics, research methodology*

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[1] *Lecturer, (a) National Institute of Legal Medicine Bucharest, Bucharest, Romania; (b) Carol Davila University of Medicine and Pharmacy, Bucharest, Romania*

[2] *Assist Prof, Carol Davila University of Medicine and Pharmacy, Bucharest, Romania*

[3] *Prof, (a) Carol Davila University of Medicine and Pharmacy, Bucharest, Romania, (b) National Institute of Legal Medicine Bucharest, Bucharest, Romania*

[4] *Polytechnic University, Bucharest, Romania*

[5] *Assist Prof, Carol Davila University of Medicine and Pharmacy, Bucharest, Romania*

* *Corresponding author, 9 Sos. Vitan Bârzești, 042122 Sector 4 Bucuresti, Romania, Phone No. 0040723791072, email: soraer@gmail.com, sorin.hostiuc@umf.ro*

Introduction

Abū ʿAlī al-Ḥusayn ibn ʿAbd Allāh ibn Al-Hasan ibn Ali ibn Sīnā or Avicenna as it is known in the Western World was one of the most important Islamic physicians and philosophers. He was born in Afsana, in present-day Uzbekistan, in 980 (Afnan, 2009). From adolescence he was drawn to the study of Greek philosophy (especially Aristotle), and medicine, which he mastered at the age of 18 according to his own sayings (Zargaran et al., 2012).

He wrote over 100 treaties of medicine, some of them containing only a few pages. His major medical work, entitled "The Canon of Medicine", was finished in 1025, and included five volumes. The first volume defined what medicine is, discussed the Elements, Temperaments, and Humors, and presented what was known at the time about human anatomy and physiology. The other Volumes treated: Pharmacology (Volume 2), Special Pathology (Volume 3), Multi-Member diseases (Volume 4), and Formulary of complex medicines (Volume 5). His main sources of inspiration were Galen (and indirectly the Hippocratic works), but also the works of other physicians from the Islamic world like Ali Ibn al Abbas al Majusi or Abu Bakr ar Razi (Tyler, 2014).

The beginning of the Volume 2 of the Canon started with a series of general conditions that the testing new drugs should fulfil (2012), further detailed in the chapter entitled "*On knowledge of the potency of drugs through experimentation*". These recommendations are presented in Table 1 and will be discussed below in correlation with current principles of research methodology and ethics.

Analogy or Experimentation?

Avicenna considered that the potency (efficacy) of a certain drug can be identified through two main methods: analogy (qiyas) and experimentation (tajribah); he recommends the later as "*experimentation leads to knowledge of the potency of a medicine with certainty after taking into consideration certain conditions*" (2012). Therefore the identification of the efficacy of a new drug needs experimentation, and the fulfilment of a series of pre-requirements (a research protocol). This approach contradicts the classical, Hippocratic approach on identifying new uses for various remedies, which was based on observation and interference, not experimental research (Miles, 2005). The use of "experimentation" in the Hippocratic works only meant the change of an ongoing treatment. For example, in the Aphorisms it/ is said: "*Do not disturb a patient either during or just after a crisis, and try no experiments, neither with purges nor with other irritants, but leave him alone*" (Hippocrates) while in Nature of Men: "*[If] it is* *clear that, of the regimen the patient is wont to use, either all, or the greater part, or someone part, is not suited to him . . . this one should learn and change . . . sometimes taking away and sometimes adding . . . and so making changes in drugging or in regimen to suit the several conditions of age, season, physique, and disease*" (Hippocrates). According to Miles the experimentation in the time of Hippocrates superficially resemble modern day "N of 1" prescriptive trials (Miles, 2005), in which the first subject (N of 1) of a certain trial will test the drug for the researcher to see whether he/she will tolerate it. However, if in modern clinical trials this is just a preliminary step, in Ancient Greece this was considered as a definite proof of efficiency (Miles, 2005). The approach of Avicenna is derived from the one found in Galen works, and developed further. Galen considered that qualified experience (*dihorismene peira*) is needed in order to determine the efficacy of a drug (Galen et al., 2015). He did not give a clear list of what conditions are needed in order to obtain reliable results from the experimental procedures. However, indirect cues are found in various works; for example, in On Critical Days, he defined three condition needed for the validation of the experimental procedures: (1) to choose patients about whom one can be certain, (2) to properly identify a crisis through clear perception not reasoning, and (3) to properly identify to stage of that particular crisis (the exact day of the crisis) (Adamson, 2013; Galen et al., 2015).

First Principle – the Tested Drug Should be Free of Excipients Able to Change the Properties of the Active Substance

An active drug can be associated with various other, pharmacologically inactive substances like anti adherents, coatings, colours, binders, disintegrants, flavours, lubricants, preservatives, sorbents, sweeteners, vehicles. All these excipients have important roles in the presentation, preservation of bioavailability of the active substance at the target site/sites. However, in the time of Avicenna the chemical interactions between most substances were unknown, making an absolute necessity, in order to properly asses the usefulness of a certain active drug, to separate its effect from the effect of other substances.

The excipients are detailed in the guidelines depending on their temperatures (heat and cold). See Table 1. Avicenna defines the constitution of a person as a mix between humours, temperatures and elements; similarly, remedies had different constitutions, making them allowed or disallowed for a certain patient depending on its particular constitution. However, before combining them with substances able to change the constitution of the mix, the physician/researcher should have been certain about the constitution of the active substance.

Second Principle – the Subject Must Suffer from a Single Condition

According to Avicenna, a composite disease is not represented by an association of disease, but on an association of morbid states that concur and generate a single disease. For example: "*the following kinds of morbid state go together to make up an inflammatory mass: (1) a disorder of temperament, this being associated with matter, (2) a perversion of form, (3) unhealthy configuration – one never meets with an inflammatory deposit without there being disfigurement, change of size and there is often displacement as well, (4) loss of continuity. This is the necessary accompaniment of the discharge of superfluities into the tissue spaces, penetrating as they do into them all, and separating one from the other in order to make space for themselves.*"

In order to assess the efficacy of a certain disease, the researcher nowadays tries to limit the subject selection criteria in a fashion that will minimize potential biases and maximize the statistical significance of the obtained results. This is the reason why we use concepts such as inclusion and exclusion criteria, placebo or randomization. Van Spall, in a review analysing eligibility criteria for randomized clinical trials showed that one of the strongly justified reason for exclusion is represented by the fact that the effect of intervention is difficult to interpret (Van Spall et al., 2007). In the Canon, Avicenna suggests that the experiment should be performed on singular conditions; this would apparently mean that they would seek cures for symptoms rather than for diseases per se. More likely, keeping in mind however the next principles, he considered that by properly identifying a specific imbalance he would be able to bring the body to a healthy state, and to properly identify the original cause and/or the condition that would be affected by the drug "*if the condition consists of two opposite diseases and the drug is tried and found beneficial in both, we cannot infer the real cause of the cure*".

Third Principle – the Drug Should be Tested on Contrary Conditions

According to this principle, testing the efficiency of a certain drug requires two study groups, having opposed conditions. A drug would be considered effective only if it would have effect on only one condition; otherwise "*is possible that the drug acted directly against one disease, and acted against the symptom of the other*" In this principle we see two important elements: the first one is the need for two study groups, a fundamental element in today's clinical trials; if however today we assess the effect of an active substance in relation to a control group (either placebo or other active agent), in Avicenna's time the "control" group was represented by subjects with a different condition. If there was a difference in the effect of the drug on those two conditions, one could speculate that the drug was active; if not, most likely more research was needed, the test being made on different conditions. The second element is represented by the need to counteract the source of the disease (the cause) and not only one of its symptoms (its effects); the reason for this approach has been detailed in the analysis of the second principle.

Fourth Principle – the Dosage/Potency Should be Correlated with the Severity of the Disease

In order to minimize the harm and maximize the efficiency of a certain remedy, the physician had to gradually increase the dosage until an optimal concentration was determined. This approach is similar to the one found in current day Phase 1 trials, in which the test subjects receive often sub-therapeutic active drugs, in increasing doses, in order to assess safety, tolerability, pharmacokinetics and pharmacodynamics of the agent. The prima-facie reason for this approach in Avicenna's time was however not non-maleficence, as is today, but beneficence (*If some of the drugs are inadequate with regard to heat when compared to the coldness of an illness, they will not be able to effect a cure*)

Fifth Principle – Time Needed to Determine the Effect

Avicenna considered that, if a drug determines a positive effect immediately, it acted on the disease itself; if however, the effect took longer to achieve, or if the results are contradictory, such a speculation could not be made.

Sixth Principle – Reproducibility

If the effect of a certain drug varies in different cases, the drug might not determine the effect, but more likely to be an accidental event. Translated in current day practice, this principle is highly similar with reproducibility, one of the main principles of the scientific method. The idea was most likely taken from Aristotle, who considered that there is no scientific knowledge associated with isolated occurrence; however, the name associated usually with the recognition of the reproducibility in science is Robert Boyle, who considered that the foundation of knowledge should be based on experimentally produced elements that should be believed by the scientific community based on their reproducibility.

Seventh Principle – Animal Studies Have Limited Uses

Avicenna considered that the use of animal studies is of little importance, as the effects might be different on humans compared to other animals. Even if this is true, most drugs have similar metabolic pathways and action mechanisms in all mammals. However, recognizing the effects on animals might have been much more difficult, and therefore significantly increase the rate of errors, which would determine the physicians at that time to do this recommendation.

Discussions

As we saw above, Avicenna's Canon of Medicine presents a series of clear recommendations regarding how a medical research should be conducted; these guidelines, even if based on an entirely different way of looking to medicine in general and the human body in particular, has a series of elements that are still identifiable in today's medical research like the need of at least two study groups to assess the usefulness of a particular drug, the need for reproducibility or the need of human experimentation to test the efficacy of a certain drug. The basic ethical principle underlying medical experimentation was beneficence, in the Hippocratic tradition; however, if in the Hippocratic tradition the physician was viewed as the ultimate resource for knowledge, in the Canon the knowledge of the physician had to come from experiments, as the subjective opinion of a physician can ne erroneous. The basic underlying ethical model of Avicenna's approach, as seen from today's perspective was utilitarian (Mill, 2010): the ultimate good of the sick needed human experimentation, not only animal experimentation - therefore the physician had to experiment on humans; the cause of the disease was more important than a particular symptom to treat - therefore, if a certain drug acted on contrasting conditions, it had to be tested on a third condition, otherwise its effect could not be properly assessed. Various authors considered that his philosophical approach seeks for a harmonious approach to the integration of the human being in nature, an approach with Aristotelian influences (Davidson, 1992; MacIntyre, 2003; Gutas, 2014), that is in apparent contradiction with the Kantian view that human beings capture nature through natural laws and equations (the legislating power of Reason) (Kant et al., 2000; Kaufman, 1997)

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Table 1. Principles of human experimentation as presented in Avicenna's Canon of Medicine

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The drug must be free from any acquired quality: this can occur if the drug is exposed to temporary heat or cold, if there is a change in the essence of the drug, or if the drug is in close proximity to another substance. Water, although cold by nature, will give warmth as long as it is heated; euphorbium, although hot by nature, will have a cold effect when cold; almond, although naturally neutral, will have a strong effect of heat if it turns rancid; and fish, although cold, is a strong source of heat if salt is added to it.

The experiment must be done on a single, not a composite, condition. In the latter case, if the condition consists of two opposite diseases and the drug is tried and found beneficial in both, we cannot infer the real cause of the cure. Example: if we treat a patient suffering from phlegmatic fever with agaric and the fever abates, this does not mean that because it was useful for a hot illness agaric possesses the property of coldness. It is possible that the drug was effective because it dissolved the phlegm or removed it; when the [phlegm] disappeared the fever disappeared. This action represents both the direct and the accidental benefit of the drug. The direct benefit relates to the [phlegm], and the indirect refers to the fever.'

The drug must be tested on two contrary conditions. If it is effective on both, we cannot judge which condition benefited directly from the drug. It is possible that the drug acted directly against one disease, and acted against the symptom of the other. Scammony, if used to treat a cold disease, would no doubt have a warming effect and bring benefit. If we try it on a hot disease, such as diurnal fever, it would also have a beneficial effect because it gets rid of yellow bile. In these cases, an experiment would be of no help in deciding whether [the drug] is hot or cold, unless we could know that it acted directly on one disease and acted on a symptom of the other.

The potency of the drug should be equal to the strength of the disease. If some of the drugs are inadequate with regard to heat when compared to the coldness of an illness, they will not be able to effect a cure. Sometimes during their application against coldness, their function for producing warmth is weakened. So it is best to experiment first using the weakest [dosage] and then increase it gradually until you know the potency of the drug, leaving no room for doubt.

One should consider the time needed for the drug to take effect. If the drug has an immediate effect, this shows that it has acted against the disease itself. If its initial effect is contrary to what comes later, or if there is no initial effect at first and the effect shows up later, this leads to uncertainty and confusion. Actions in such cases could be accidental: their effect is hidden at first and later comes into the open. The confusion and uncertainty relate to the potency of the drug.

The effect of the drug should be the same in all cases or, at least, in most. If that is not the case, the effect is then accidental, because things that occur naturally are always or mostly consistent.

Experiments should be carried out on the human body. If the experiment is carried out on the bodies of [other animals] it is possible that it might fail for two reasons: the medicine might be hot compared to the human body and be cold compared to the lion's body or the horse's body … The second reason is that the quality of the medicine might mean that it would affect the human body differently from the animal body

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ANCIENT GREEK ROOTS OF MODERN ADVOCATING FOR ANIMAL PROTECTION AND WELFARE

ŽELJKO KALUĐEROVIĆ[1]

REZUMAT. Protecția animalelor și starea de bine. Cei care își pun întrebări referitoare la percepția antropocentrică dominantă a cosmosului devin din ce în ce mai vocali în creșterea cerințelor (bio)etice pentru o nouă rezoluție a relației dintre ființele umane și alte viețuitoare, susținând că tradiția filosofică și teologică occidentală a cauzat prezenta criză ecologică, și nu pe cea doar ecologică. S-au făcut tentative pentru a stabili o nouă legătură prin relativizarea, de multe ori, a diferențelor dintre om și ființele non-umane, atribuindu-le acestora proprietăți și categorii specific umane, precum demnitatea, statutul moral și drepturile. În acest studiu, autorul investighează opiniile care deviază de la filosofia occidentală dominantă, în sensul expansiunii non-antropocentrice al eticii și le găsește fundamente în scrieri ale primilor filosofi ai naturii, unde se găsește un tip de mixtură de elemente corporale, i.e. rudenia tuturor formelor de viață. Pitagora, Empedocle, Anaxagora, și Democrit, în acest context, considerau anumite animale ca fiind sacre i.e. Ei credeau că animalele sunt responsabile pentru ceea ce fac și că au suflet, inteligență, conștiință, abilitatea de a gândi, minte și rațiune. Autorul, în final, crede că soluția pentru criza menționată nu rezidă doar dintr-o simplă reconsiderare a animalelor, i.e. prin atribuirea de caracteristici emoționale și intelectuale similare sau identice tuturor ființelor vii, ci din abordarea paideutică adecvată care ar trebui să dezvolte în oameni un model bioetic inerent al acceptării animalelor ca niște ființe ce merită un tratament moral, respect și comportamente adecvate.

Cuvinte-cheie: *antropocentrism, non-antropocentrism, anticipare, presocratici, om, animale, înrudire, responsabilitate, protecție, stare de bine*

ABSTRACT. The advocates of questioning the dominant anthropocentric view of the cosmos are becoming increasingly louder in raising (bio)ethical requirements for a new resolution of the relation between humans and other living beings, by claiming that the following of western philosophical and theological tradition has caused the present ecological, and not merely ecological crisis. Attempts are being made to establish a new relationship by relativizing the differences between man and non-human living beings often, by attributing specifically human properties and categories, such as dignity, moral status and rights, to non-human living

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[1] *University of Novi Sad, Faculty of Philosophy, Novi Sad, Department of Philosophy, dr Zoran Đinđić 2, 21000 Novi Sad, Serbia. Email: zeljko.kaludjerovic@ff.uns.ac.rs*

beings. In this paper the author investigates the antecedents of the views deviating from the mainstream Western philosophy, in the sense of non-anthropocentric expansion of ethics, and finds them in the fragments of the first philosophers of nature, in which a kind of mixture of corporeal and psychical elements, i.e. the kinship of all varieties of life is emphasized. Pythagoras, Empedocles, Anaxagoras and Democritus, in this context, considered certain animals as sacred, i.e. they believed that animals are responsible for what they do and that they have a soul, intelligence, consciousness, ability to think, mind and reason. The author, finally, believed that the solution for the mentioned crisis does not lie in a simple levelling of animals upwards, i.e. in the attribution of similar or identical emotional and intellectual characteristics to all living beings, but in the adequate paideutic approach which shall develop in people an inherent bioethical model of accepting animals as being that deserve moral treatment, respect and adequate treatment.

Keywords: *anthropocentrism, non-anthropocentrism, anticipation, pre-Socratics, man, animals, kinship, responsibility, protection, welfare*

The basis of modern civil epoch is founded on logocentric and homocentric image of the world, the meaning of which, in Aristotle's trail, originates from the high level of confidence in human *logos* abilities. Logocentrism, in other words, represents the view that the principle of understanding and reason is the basis of man's world but also the universe as a whole. Homocentrism, on the other hand, as a modern worldview is based on Stagirites' vision of man as a separate being among other natural beings. Such an understanding comes from the belief that the ultimate basis of our world is not determined by nature, god, accident or coincidence, but that man, as a free individual, with his powers is the basis of human historic world.

By claiming that only man, among all living beings (λόγον δὲ μόνον ἄνθρωπος ἔχει τῶν ζῴων, *Pol.*1253a9-10), possesses ability of speech (λόγον) Aristotle emphasizes the difference between humans and other living beings also in the segment of organized community for life (*Pol.*1253a8-18).[2] By defining man as the only living being which possesses speech, the Stagirites at the beginning of the *Politics* in fact presented one of his three known authentic definitions of man. The speech, also, expresses something that is useful and something harmful (τὸ συμφέρον καὶ τὸ βλαβερόν), as it also tells what is just and what is unjust (τὸ δίκαιον καὶ τὸ ἄδικον). Another definition of man is that he is the only living being which is capable of distinguishing good from evil (ἀγαθοῦ καὶ κακοῦ), i.e. just from unjust (*Pol.*1253a15-18). Third, and certainly most well known Stagirites' definition of man is that he is by nature a

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[2] For more details see: Ž. Kaluđerović, „Aristotelovo razmatranje *logosa*, „volje" i odgovornosti kod životinja", u: *Filozofska istraživanja*, 122, god. 31, sv. 2, Zagreb 2011, pp. 311-321.

social or political animal (ἄνθρωπος φύσει πολιτικὸν ζῷον, *Pol.*1253a2-3). Man is "by nature", i.e. by his original constitution, which distinguishes him from other natural species, a being that can realize its own humanity only in a community with other human beings. Men base their own communality on *logos* in the community as a community, organizing it according to agreed and accepted rules, customs and laws.

Anthropocentricity of this view of the world was an important reason why our dominant technological civilization has not been developing in harmony with nature, but more often in opposition to it. None of man's acts in the past could essentially affect the spontaneity of the being of our planet, since the changes in the natural environment initiated by it left no significant mark on the Earth itself. The rapid development of technics and technology in this as well as in the last century placed man into a completely new moral situation. The new situation is reflected in the fact that modern man needs to accept the responsibility for the effects which are not the result of action of any individual, but represent a collective act, an act, in Husserlian terms, "of anonymous functioning subjectivity". The effects of modern techniques and technology therefore imply a completely new situation for the traditional ethics, because to a certain extent the postulate of the anthropocentric view of the world that humans as a species are unquestionable in their existence on the Earth is thus being derogated. Ensuring the survival of the human species in the foreseeable future is a task whose realization should be contributed by new knowledge in ethics[3], i.e. bioethics[4]. In order for this fact to be confirmed bioethics should review the power of technics and technology, whose effects are thus gaining a philosophical indication considering how significant they are to the life of the human species. Meanwhile, nature has begun to "revolt" strongly against uncontrolled human activity in the form of changing the climate on Earth ("global warming"), but also by increasing the number of diseases and plagues in humans and animals. The burning pyres during so called "mad cow", "bird flu" or "swine flu" crises, represent a kind of warning to men and an indication of more serious issues they could be facing. As a commandment a new order of life is imposing, in which man will become aware that the Earth can hardly tolerate his often reckless acts, and which requires the cooperation of man with the world that surrounds him.

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[3] It would be possible therefore, on the trail of H. Jonas, to establish a new imperative: *"We should not compromise the conditions for an indefinite continuation of humanity on earth"*. H. Jonas, *Princip odgovornosti*, V. Masleša, Sarajevo 1990, p. 28.

[4] F. Jahr coined the original term Bioethics and formulated a Bioethics Imperative: *'Respect every living being on principle as an end in itself and treat it, if possible, as such!'*. F. Jahr, "Reviewing the ethical relations of humans towards animals and plants", p. 4, in: A. Muzur, H.-M. Sass (Eds.), *Fritz Jahr and the Foundations of Global Bioethics. The Future of Integrative Bioethics*, Lit Verlag, Berlin – Münster – Wien – Zürich – London 2012.

The advocates of questioning the dominant anthropocentric view of the cosmos by non-anthropocentric expansion of ethics, are becoming increasingly louder in raising (bio)ethical requirements for a new resolution of the relation between humans and other living beings.[5] Attempts are being made to establish a new relationship by relativizing the differences between man and non-human living beings, i.e. by attributing specifically human qualities and categories, such as dignity, moral status and rights, to non-human living beings, but also of feeling, memory, communication, consciousness and thinking. It seems just as inspiring today as it was in ancient times to ask and to look for the answer to the question of whether the animals[6] are able and to what extent to develop their feelings. Can animals memorize, and if so, which forms of memory they possess? What is their communication like and how sophisticated it is? Ultimately, are animals' conscious beings which can think distinguishingly, and can it be said to have a neurology?

If some of the answers to these questions are positive or positively inclined, we usually talk about a discovery of a surprising world, of animals as complex beings that live rich and sensual lives, of their relation and analogy with humans, i.e. about a revolutionary concept that is not older than half a century. Leaving aside, for the moment, a deeper discussion about the meaning of certain terms, such as "communication", "consciousness" and "opinion", in order to be able to talk about their truthfulness in regards to animals, the author of this paper believes that the departure from mainstream Western thought and philosophy is not a novelty of the second half of the XX century. Namely, different animal rights movements were organized in Europe much earlier. In London, for example, already in 1824 the first society for the prevention of cruelty to animals was established, whereas a regulation pertaining to animal welfare in the UK was adopted in 1911, and, including numerous amendments, it is still in force today. In

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[5] Some of the leading authors, whose views are representative of contemporary discussions about the new regulation of the relationship between humans and animals are undoubtedly P. Singer, T. Regan and K. M Meyer-Abich. They, to put it briefly, believe that animals are beings capable of suffering, which have their own interests and needs that are partly similar to the basic needs of men; if there is such a similarity, then, the principle of equality requires that the interests of animals are respected equally as the similar interests of humans; animals finally have their own value, which for some derives from their consciousness, while for others additional importance lies in the kinship of humans and animals.

[6] According to "European Convention for the Protection of Vertebrate Animals used for Experimental and Other Scientific Purposes", "animal" means any live non-human vertebrate, including free-living and/or reproducing larval forms, but excluding other fetal or embryonic forms. In the Preamble of this convention it is stated that animals have capacity not only for suffering but also for memory, so therefore man has a moral obligation to respect all animals (http://conventions.coe.int/treaty/en/treaties/html/123.htm). In Article 5, point 13 of the Law on Animal Welfare of the Republic of Serbia, "animal", for example, is defined reductively but unambigiously as any vertebrate which has a capacity to feel pain, suffering, fear and stress: (http://www.paragraf.rs/propisi/zakon_o_dobrobiti_zivotinja.html).

a classic passage that J. Bentham wrote even earlier, namely in 1780, it is asserted: “The day may come, when the rest of the animal creation may acquire those rights which never could have been [withheld] from them but by the hand of tyranny. The French have already discovered that the blackness of the skin is no reason why a human being should be abandoned without redress to the caprice of a tormentor. It may come one day to be recognized, that the number of legs, the luminosity of the skin, or the termination of the sacrum bone, are reasons equally insufficient for abandoning a sensitive being to the same fate. What else is it that should trace the insuperable line? Is it the faculty of reason, or, perhaps, the faculty of discourse? But a full-grown horse or dog is beyond comparison a more rational, as well as a more conversable animal, than an infant of a day, or a week, or even a month, old. But suppose the case were otherwise, what would it avail? [T]he question is not, [“c]an they reason?”, nor, [“c]an they talk?”, but [“c]an they suffer?”[7]

The search of antecedents of levelling the differences between humans and other living beings, stems from the very origins of science i.e. from the first philosophers of nature, on the basis of whose extant fragmentary manuscripts it can be established that they anticipated most of the latter modalities of non-anthropocentric approaches. In order to understand the views of philosophers of nature who were active in the so-called cosmological period, it is necessary to leave aside dualistic conceptions, especially those that on the Cartesian trail emphasize the sharp distinction between matter and spirit. For early *physicists*, in particular, there was no inert matter that due to the logical necessity would require the division of the first principle into the material and efficient element. When accepting any principle as the sole source of origin, automatically, at least to the same extent, its inherent mobility was borne in mind as well. In short, the standing point of the first philosophers still belonged to the age when there was no serious distinction between body and soul, organic and inorganic.[8] In their minds rather figured some kind of obfuscation of corporeal and mental elements, as this is the time when it was difficult to imagine the body without a soul or the soul without matter. The first philosophers, consequently, understood thinking as something corporeal similar to sensation and generally understood that like is understood as well as perceived by like. The expected consequence of such approach is the assertion of some Pre-Socratic that not only man but also all other beings have consciousness, thinking and practical wisdom.

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[7] J. Bentham, *An Introduction to the The Principles of Morals and Legislation*, pp. 4-5. Website: http://www.mesacc.edu/~barsp59601/text/105/notes/read/bentham.pdf.

[8] As it is evident from Aristotle’s claim that Thales thought that the stone (magnet) has a soul because it can cause movement. Diogenes Laertius (I,24), relying on the authority of Aristotle (*De An*. 405a19-21) and of Hippias (**DK**86B7), claims that Thales and ascribed to non-ensouled beings, i.e. to non-living beings (ἀψύχοις) to have soul (ψυχάς) as well, repeating the example with stone magnet and adding the amber.

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Indirectly preserved Pythagoras' views confirm a universally known fact that he was the first to bring to Greece the doctrine that all living beings that were born are kindred (ὁμογενῆ). The idea that all forms of life are kindred brought into connection not only humans with animals and plants, but also indicated that human soul, however the truth is only after purification, can achieve melding with eternal and divine soul, to which it belongs by its own nature. This kinship of all varieties of life was a necessary prerequisite for the Pythagorean doctrine on the transmigration of souls (παλιγγενεσία). Xenophanes reports about *palingenesia* as the Pythagoras' doctrine by a well known statement that once when Pythagoras saw some people beating a dog and advised them to stop, since in the yelping of the dog he recognized the soul of his friend (**DK**21B7).[9] This fragment shows that the Pythagorean belief in renewal or rebirth of the soul was already so widely known in the sixth century BC that it got parodied. Pythagoras' recognition of his friend's soul embodied in a dog illustrates, on the other hand, the transfer of personal identity on the *psyche*, which means that a personality somehow survives in the migrations of the soul and that there is a continuity of identity. The conclusion that can be derived, at least implicitly, is that ensouled beings, therefore animals, but also certain plants, in a sense, are conscious beings.

A structural difficulty of such a view is how to fit the kinship of entire nature with logical implications that thus plants should not be consumed either since they, according to Pythagoreans, are living beings and a part of the communion of nature. As Diogenes Laertius (VIII, 28) reports Alexander Polyhistor notes that in the *Memories of Pythagoras* he found the solution to the paradox. Pythagoreans believed that all things live which partake of heat, and this is why the plants are living beings (ζῷα), but not all have a soul. The soul is a detached fragment of

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[9] From this fragment (**DK**21B7) it is evident why kinship of all beings which is associated with the doctrine of the transmigration of souls is at the basis of the Pythagorean ban on the eating of animal flesh. Since the topics discussed in the Pythagorean fraternity caused great controversy, and that they themselves are very difficult to systematize and interpret consistently, it is not surprising that attitudes about (non) use of animal meat are not uniformly understood in the latter times. In short, the views of Pythagoreans ranged from the belief in a complete ban on the use of animal meat in the fraternity, through refraining from eating just certain species of animals, to a categorical denial of any bans on meat consumption. For more details see: W. K. C. Guthrie, *A History of Greek Philosophy I*, Cambridge University Press, Cambridge 1962, pp. 182-195; J. Burnet, *Early Greek Philosophy*, The World Publishing Company, Cleveland and New York 1962, pp. 93-96; B. Pavlović, *Presokratska misao*, ΠΛΑΤΩ, Beograd 1997, pp. 101-103; J. F. Mattéi, *Pitagora i pitagorovci*, Jesenski i Turk, Zagreb 2009, pp. 19-28.

either, the one hot and the one cold. The soul is different from life[10], it is immortal because immortal is also that from which it separated. Plants, therefore, have a life, but not all of them have souls which means that some of them are suitable for consumption.[11]

Subsequently Ovid presented Pythagoras as an author who emphasized that even if someone had the right to kill a dangerous animal, it did not mean he may not eat it (*Metamorphoses* 15.110). Some animals were considered sacred, and it was deemed that if eaten they could lessen man's closeness to gods. That is why the fraternity was forbidden to eat white roosters because they are dedicated to the Moon, as it was not allowed to touch the sacred fish, i.e. red mullet and blackmail because it was sacred to the terrestrial gods.

According to the testimonies of Aristoxenus (**DL**, VIII,20), Pythagoras reportedly also forbade to eat plough oxen. This assertion, actually, less likely suggests the kinship of men and oxen and rather speaks of the pragmatic reasons for abstaining from eating draft animals.[12] By putting human beings into the same rank with animals, Pythagoras demanded they must be viewed as kins and friends and not to be harmed under any circumstances.[13] He thought that this promotes peace, because if men started to abominate the slaughtering of animals as something illegal and unnatural, they would not regard killing of a human being as an honourable act either, and therefore would not initiate wars. This "indirect" duty towards animals was later recognized by Clement of Alexandria,

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[10] W. Jaeger makes a similar conceptual distinction interpreting Anaximenes. He says that Anaximenes uses the word ψυχή in the sense of "soul" and not in the sense of "life", and this he explains by the fact that the air (ἀήρ) is bearer of life. For Anaximenes the basic substance, according to Jaeger, is already alive and it refers to the visible corporeal world as the soul to the human body. W. Jaeger, *The Theology of the Early Greek Philosophers*, Oxford University Press, Oxford 1967, p. 79.

[11] Plants that were not acceptable as food were broad beans and mellows. For the deatiled reasons why Pythagoreans abstained from eating bread beans and mellows see: Jamblih, *Pitagorin život*, DERETA, Beograd 2012, p. 69.

[12] Pythagoras, however, believed that food helps in education of men, if it is of good quality and regular, so he consented to eating everything that leads to a healthy body and a keen mind. He was also convinced that adequate food favors the skill of prophecy, purity and chastity of the soul, i.e. of practical wisdom and virtue.

[13] Pythagoras was the first philosopher who sometime after 530 BC practiced the use of barley cakes, honey and olive oil instead of animal sacrifice (Iamblichus, in the part when he is talking about everyday life of Pythagoreans says that before dinner they used to make sacrifice of *"fumigations and frankincense"*, and adds that *"flesh of sacrificial animals, as they rarely fed on fish"* was also placed before them. Jamblih, *Pitagorin život*, DERETA, Beograd 2012, p. 63. Earlier in the book Iamblichus notes that it is incorrectly attributed to Pythagoras that he instructed athletes to eat meat instead of dried figs (Ibid, p. 17; this story is also repeated by Diogenes Laertius. D. Laertije, *Životi i mišljenja istaknutih filozofa*, BIGZ, Beograd 1973, p. 270). This practice, of course, did not include ordinary citizens but only members of the fraternity. The founder of the fraternity also prescribed that ensouled beings are not to be used for nutrition, since they are kindred to humans by means of community of life, identical elements and relationships between them, as well as by unified breath that pervades them all.

Maimonides, Thomas Aquinas, Kant, and some modern philosophers, and is still today used as an argument why we should not carry out experiments on animals. The reason is potential subsequent dehumanization of man himself.[14]

Empedocles, a century later, says that all beings have thought (πεφρόνηκεν), i.e. that they have understanding or consciousness, and adds that this is so by the will of Fortune (**DK**31B103). Related to this is Empedocles' claim from the end of fragment 110 (**DK**31B110) that everything can have practical wisdom and have its share of thought.[15] In the introduction to this fragment it is even possible to find the thesis that all parts of fire, whether they are visible or not, can have practical wisdom (φρόνησιν) and the ability to think (γνώμην), rather than a share of thought (νώματος). Sext Empiricus adds that it is even more astounding that Empedocles holds that everything has a discernment facility (λογικὰ), including plants.[16] This view shows that according to Empedocles as well, who even more explicitly ascerted it than Pythagoras, the idea of kinship of all living not only has a vital-animal meaning but to a certain extent the mental meaning.

In his verses Empedocles is also telling about the sacrifice by using water, honey, oil and wine, i.e. he sings about old times when love and compassion for the kin were above everything else, about absence of killing and the treatment of other living beings as one's own household members. Instead of living beings i.e. animals, people, according to him, tried to propitiate the queen Kupris by sacrificing[17] myrrh, frankincense and honey, statues and "with pictures of animals" (γραπτοῖς τε ζώιοισι). In these times, according to the philosopher of Akragas, everything used to be tame and gentle towards man, including birds and wild animals. The sacrificing which Empedocles mentions did not include destruction of plants either, which also is probably due to the fact that in fragment 117 (**DK**31B117) he recorded that he had been a boy and a girl, a bird and a fish, even a plant i.e. a bush.[18]

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[14] Similiarly writes already mentioned "father" of European bioethics F. Jahr: *"... Senseless cruelty towards animals is an indication of an unrefined character becoming dangerous towards the human environment as well"*. F. Jahr, „Zaštita životinja i etika u svom međusobnom odnosu", p. 214, u: I. Rinčić, A. Muzur, *Fritz Jahr i rađanje europske bioetike*, PERGAMENA, Zagreb 2012.

[15] Empedocles' view, from the fragment 110 (**DK**31B110), that *"that everything has practical wisdom and has its share of thought"* can be relatively easily correlated with Parmenides' view that *"all things have some kind of cognition"* (**DK**28A46). As far as Parmenides is concerned, i.e. the relevance of his views for subsequent establishment of non-anthropocentrism, paradigmatic is fragment 16 (**DK**28B16). For more details see: Ž. Kaluđerović, „Presokratsko razmatranje φρόνησις-a i αἴσθησις-a", u: *Filozofska istraživanja*, 135, god. 34, sv. 3, Zagreb 2014, pp. 394-396.

[16] That this is not so unusual view as Sextus Empiricus writes, confirm quoted paragraphs of Pythagoras and Parmenides as well as the fragments following Anaxagoras and Democritus.

[17] The very idea of sacrifice is often regarded as a morally mediated communication of people with gods or deities.

[18] Empedocles obviously, as well as Pythagoras, held the view that one's soul may transmigrate both among humans and among animals and plants.

Empedocles says (**DK**31A70) that trees represent a primordial form of life ("first living things" (πρῶτα τὰ δένδρα τῶν ζώιων), which had survived even to his time. Moreover, they had existed even before the Sun spread and the day and night were distinguished.[19] Doxographer Aetius, who reports the thoughts of the Sicilian, indicates to the analogy of plant and animal life, confirming it by using the term life (ζῷα) for the trees, the word that was usually restricted to animals. Empedocles, just as Pythagoras, if we use modern terminology, was convinced that there was no sharp genetic difference between plant and animal worlds. Therefore, without any hesitation he makes comparisons and analogies that today may seem strange, at least. For example, that "tall olive trees … bear eggs first", i.e. that the nature of seeds is equal to the nature of eggs. Or, that hair, leaves, scales and thick feathers of birds are the same, while an ear the philosopher from Sicily calls a fleshy sprout. When in the fragment 140 (**DK**31B140) Empedocles records that one should abstain from laurel leaves, what he actually had in mind was its consumption, and possibly the same is implied by his addressing the "Wretches, utter wretches", in the next fragment 141 (**DK**31B141), telling them not touch the beans with hands. Laurel, Apollo's sacred plant, according to Empedocles, is a kind of the "king" of plants such as the lion is the king of animals. In fragment 127 (**DK**31B127) he says that, within their own species, laurel and lion are the best habitats for the human soul.

Empedocles urges his disciples to abstain from eating all ensouled (living) beings (ἐμψύχων), since eaten bodies of living beings (ζώιων) are where penalized souls reside. He believes that he himself is one of them, the one who has killed and eaten, and that it is by purification that prior sins in connection with food should be treated. Sacrificing a bull and eating his limbs, as this philosopher from Sicily says in part of the original fragments entitled as "Purification", was "the greatest abomination" for man. Anyone who gets his hands dirty by murder shall experience the fate of "evil demons", that is for 30,000 years[20] he shall wander outcast far away from the blissful, leading a hard life and shall incarnate in the forms of many creatures. That is exactly what Empedocles claims about himself, that he is "banished by the God and a wanderer". Subject of man's exile from the divine home is taken, then, by Plotinus and Porphyry, repeated in different contexts in the works of Aurelius Augustine, and used by Plutarch as a consolation for political persecution. Basically, according to Empedocles the sin that broke the golden era of tranquillity and general leniency was killing and eating animals.

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[19] In the Bible, in the first book of Moses ("Genesis"), for a comparison, it is said that the night and day, were distinguished and named on the first day and the Sun on the fourth day of creation, while grass, plants and trees were created not earlier than on the third day. For more details see: *Biblija*, *Sveto pismo Starog zavjeta*, „Prva knjiga Mojsijeva", Sv. arh. Sin. Srp. prav. crk., Beograd 2007, pp. 9-10.

[20] That is three times ten thousand years, while one *myriad* according to Plato (*Phaedr.* 248e) is the time required for the soul to return to the place it came from.

Empedocles' case shows that men are living beings that make mistakes and that they owe to animals the justice that is based on the mutual kinship. When Aristotle in *Rhetoric* (1373b6-17) talks about the special and general laws, the general laws he simply called natural laws. The explanation of natural laws is linked with general understandings of the just and unjust in harmony with nature, which, according to him, has been recognized by all nations. The Stagirites believes that with Empedocles it is just that very kind of law, i.e. that the philosopher from Agrigento referred to that right when he was forbidding to kill living beings, since it is impossible for ones to do that justly and the others to do that unjustly. Empedocles (and Pythagoras) claims (**DK**31B135) that for all living beings applies only one legal norm, and that those who had hurt a living creature shall receive punishments that cannot be redeemed.

Empedocles' (and Pythagoras') followers repeat that men are kin not only to each other or with the gods, but with living beings which do not have the gift of speech. Something common that connects them all is a breath (πνεῦμα), as a kind of soul (ψυχῆς), which extends throughout the entire cosmos and unites men with all of them. Therefore, if man would be killing or eating their flesh, they would commit injustice and sin towards deities (ἀσεβήσομεν) to the same extent as if they destroyed their relatives (συγγενεῖς). For that reason the Italian philosophers advised man to abstain from ensouled (living) beings (ἐμψύχων) arguing that it is a sacrilege committed (ἀσεβεῖν) by "those who drench altars with warm blood of the blessed" (**DK**31B128). Transmigration, thought Empedocles, means that men are literally killing their relatives, i.e. that the man who eats meat can eat his son, as well as the son can eat his father, or that children can eat their mother because they changed form.

Anaxagoras, then, often cited the reason as the cause of what is good or right, while in other places he asserts that soul is the cause. The philosopher from Clazomenae asserts that the reason exists in all living beings (ζῴοις), both large and small, in both the valuable and in those less valuable.[21] Anaxagoras did not always consider reason (νοῦς) as something that corresponded to practical wisdom (φρόνησιν). Aristotle, however, believes that the reason is not equally inherent in all living beings, not even in all of the men, while in some

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[21] *De An*. 404b1-5. Aristotle probably has in mind the parts of Anaxagoras' fragment 12 (**DK**59B12). The Stagirites wondered whether Anaxagoras identified *Nous* and *psyche*, or he made the difference between them (About this dilemma writes H. Cherniss. H. Cherniss, *Aristotle's Criticism of Presocratic Philosophy*, OCTAGON BOOKS INC., New York 1964, p. 293). The burden of decision-making about this issue is not reduced by reference to Anaxagoras' fragment 11 (**DK**59B11), in which he asserts that in everything there is a share of everything, except reason, but there are some things in which reason, too, is present. Archelaus, imitating Anaxagoras, held (**DK**60A4) that reason is equally peculiar to all living beings, i.e. that every living being uses reason and that the difference occurs only in the speed of its use.

Anaxagoras' fragments νοῦς simply means ψυχή in general. Somewhat later (*De An*. 405a13-14) the Stagirites cautiously repeats that it seems to him that the philosopher from Clazomenae still distinguishes between the soul and the reason. The objection placed at the expense of Anaxagoras is that he treats soul and reason as having the same nature, regardless of the fact that he sets reason as a principle.[22]

W. K. C. Guthrie said that in Anaxagoras the degrees of reality showed that the soul at its lowest level is that what gives the living beings power of self-motion, while the ability of cognition of beings is at higher levels. When he postulated reason as the principle of all movement Anaxagoras linked all the layers of reality. For animate beings reason is an internal faculty but for inanimate things it is an external force.[23] Implicitly present in Empedocles, the idea of degrees of reality will be further elaborated by somewhat older philosopher, Anaxagoras, perhaps the first on in the long line of the history of theory of levels from Antiquity to N. Hartmann. It is not, therefore, surprising to find the places where it is stated that the plants also possess a certain degree of sensation and thought. In addition, Anaxagoras (and Empedocles) says that plants are driven by desire, that they have feelings, joy and sadness (**DK**59A117).

Anaxagoras also asserts that plants are animals (ζῷα εἶναι), and as evidence of his claim that plants can feel "joy and sorrow", he mentions the changing of leaves. Despite the arguments of other ancient philosophers that plants and many animals do not breathe, the philosopher from Clazomenae was of the opinion that plants do breathe (πνοήν).[24] Anaxagoras, moreover, in the (Pseudo) Aristotelian manuscript *De plantis* was presented, together with Empedocles and Democritus, as the proponent of the thesis that plants have reason and ability to think. The reason is, according to Anaxagoras, present in all living beings (humans, animals and plants) and it is the same in all of them. The differences between these beings are not a consequence of essential difference among their souls, but a consequence of differences among their bodies, which either facilitate or hinder fuller functioning of *Nous*.

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[22] The Stagirites probably best expressed his disappointment with Anaxagoras' use of reason in Met.985a18-21. Theophrastus says (**DK**62.2) that Kleidemos does not hold, as Anaxagoras, that reason is the principle of everything. Probably the *Nous*, according to Kleidemos, may not be different from the rest of the soul. In the following fragment (**DK**62.3), Theophrastus writes that Kleidemos thinks that plants (τὰ φυτά) consist of the same elements as living beings (ζώιοις), and if they consisted of more opaque and colder elements, they would be further from being living beings (ζῶια).

[23] W. K. C. Guthrie, *A History of Greek Philosophy II*, Cambridge University Press, Cambridge 1965, p. 316.

[24] *De plantis* 816b26. From such a perspective the attitude Diogenes of Apollonia (**DK**64B4) that Men and all other animals (ζῶια) live upon air by breathing it, and this is their soul (ψυχή) and their reason (νόησις), while, when this is taken away, they die, and their reason (νόησις) fails, seems very "common".

The idea of kinship of entire nature was not an exclusive Italian paradigm but its traces can be found in the Ionian tradition as well. Anaxagoras adopted a widely spread notion that life was originally generated out of moisture, heat, and earth. He actually says that living beings were first created "in the humidity" (ἐν ὑγρῶι) and later from one another. Air for Anaxagoras contains seeds of all things, and they were brought down from *air*, together with water, and they generated plants. To this Theophrastus' statement on Anaxagoras, a Christian thinker Irenaeus adds that previously said applies to animals as well, i.e. that "animals resulted from seeds that fell from heaven to earth" (**DK**59A113). Irenaeus says about Anaxagoras that he was nicknamed an atheist (*atheus*), perhaps because for him the heaven is no longer the father who needs to fertilize the mother Earth by rain, in order for the rain, as his seed, then to grow in the warmth of the bosom of the Earth. Pericles' friend explains things by mimicking to a certain extent mythological forms, however in a rationalized discourse of his viewpoints the seed simply descends to Earth from heaven by rain and germinated with the aid of heat.

At the end of the series of pre-Socratics, whose views are relevant for the latter attempts to establish non-anthropocentrism, there is Democritus, who was about forty years younger than Anaxagoras. He is mentioned together with Empedocles as a proponent of the viewpoint that it is necessary to identify φρόνησις with αἴσθησις.[25] In the manuscript *On the Soul* (404a27-29) it is said that for the philosopher from Abdera soul and reason are the same things, since the phenomenon (φαινόμενον) is the truth.[26] In the following part of this manuscript the thesis about the identity of soul and reason in Democritus is repeated, together with the claim that he does not consider the reason as a kind of power to achieve the truth.[27]

Democritus (and Parmenides and Empedocles) argued that animals have a kind of ability to think (**DK**28A45). He believed that animals are responsible for what they do, and that they can be the subject of a just punishment. In fragment 257 (**DK**68B257), the Abderite writes that only some i.e. certain animals may be killed. The following fragment specifies that unpunished shall remain the one who kills the animals that cause harm and which want (θέλοντα) to cause harm. Now the question is raised what are these "some" animals that may be killed? What are the animals that cause harm and can act intentionally? Democritus may have

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[25] *Met.* 1009b12-31. In the part of fragment 105 (**DK**68A105) Philoponus, in Aristotle's footsteps, asserts that Democritus says that the soul is not divided into parts and that it has not many abilities, adding that thinking and sensation are the same. Aetius confirms (**DK**67A30) that for atomists thinking and sensation have to depend on the physical mechanism. Leucippus and Democritus, according to his interpretation, consider that sensations (αἰσθήσεις) and thoughts (νοήσεις) are only changes of the body.

[26] See also *GC* 315b9-15. The clues for not making a distinction between νοῦς and ψυχή Democritus, except in Homer, could also find in Herodotus (ἐκ παντὸς νόου, *Istorija*, VIII,97.2).

[27] Aristotle similarly records in *De An*. 405a8-13 and in *De Resp*. 472a6-8.

invoked the distinction, which was attributed to Pythagoras, among wild animals like foxes, reptiles, lions or wolves that could be killed without any fear and farm animals, cattle or horses, which should not been killed, because they probably belonged to someone and were subject to standardized care. Wild animals are ἀδικεῖν which means "behave badly" or simply "harm", while the term δίκαιος implies that domestic animals are "as they should be", or that they behave "appropriately" and "trained". In the following fragment 258 (**DK**68B258) Democritus said that everything that unfairly (παρὰ δίκην) causes harm should be killed. Are there any creatures that do harm fairly (κατὰ δίκην)? A potential positive answer lies in the early understanding of the noun δίκη as "something normal", what is "normal", and therefore also "right". Wolves and foxes which ravage forests do not behave παρὰ δίκην. They do it when they break into corrals with sheep or yards with chicken, so they should be killed at all costs because then they "cause unjust harm". The fragment 259 (**DK**68B259), finally, refers to the fact that the ferocious beasts and reptiles should be killed because they are enemies in any framework.[28]

Democritus, on the other hand, was convinced that humans in some of the most important skills were "disciples" of animals. He scoffs at the characteristic of humans who tend to praise the animals that are capable of learning something easily (**DK**68B154). Democritus, on the contrary, argues that the observation of spider activity gave man an idea of weaving and mending, by mimicking swallows man, according to him, came to realize how houses are built, while singing they learned by imitating a swan and nightingale.

The philosopher from Abdera believed (**DK**68A117), similarly to Parmenides and Empedocles, that there is a small part of the soul in all things, and therefore in plants as well[29]. Given that he derived thinking (φρονεῖν) from the composition of the body, Democritus (**DK**68A135 (58) simply says that it occurs when the soul is in a suitable condition with respect to its mixture. Plutarch reports that Democritus' disciples thought that a plant is an animal that grows from the soil (ζῷα ἔγγεια).[30] Unnamed disciples of the philosopher from Abdera believed, in other words, that there was no substantial difference between plants and animals, except that the plants are rooted in the soil.[31]

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[28] For more details see the book of the author of this article. Ž. Kaluđerović, *Presokratsko razumevanje pravde*, Izdavačka knjižarnica Zorana Stojanovića, Sremski Karlovci-Novi Sad 2013, pp. 235-252.

[29] Following the trail of Parmenides, Democritus in the same fragment 117 (**DK**68A117) argues that dead bodies have a share in a kind soul, and that they have ability of sensation as well.

[30] The same thought Plutarch attributed (**DK**59A116) to Anaxagoras' and Plato's disciples. Plato in the *Timaeus* (77a) says that the plant is *"another kind of animal"* (ἕτερον ζῷον) and that *"a nature akin to that of man"* (τῆς γὰρ ἀνθρωπίνης συγγενῆ φύσεως φύσιν). Somewhat later (*Tim.* 90a), the Athenian says that man is *"a plant not of an earthly but of a heavenly growth"* (φυτὸν οὐκ ἔγγειον ἀλλὰ οὐράνιον).

[31] In the part of the paper on the philosopher from Clasomenae paraphrased is also the manuscript *On plants* (815b16-17), in which the view of three post-Parmenidian philosophers is stated that plants have both νοῦν and γνῶσιν.

Some pre-Socratics were, if we would review what was previously stated, convinced that there was an intrinsic affinity of the entire nature, so without a lot of normative acts but on the basis of a deep belief in their own closeness with other living beings they refused to harm them and use them as food. By levelling animals "upwards", i.e. by attributing similar or identical emotional and intellectual characteristics to all living beings, the first Greek philosophers paved the way for subsequent attempts at scientific, philosophical but also legal modifications of their status, which culminated in the last century.

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The last around fifty years on the European continent were marked by dramatic changes in the area of ethical-moral and legal- political regulation of the protection and welfare of animals. They are the result of legislative activities of individual states[32] as well as of the transposition into the national legislation of a large number of relevant documents adopted under the auspices of the European Council and the various decisions of the bodies of European Union, and of the standardizing of the legislations of European countries.[33] The majority of the adopted laws and regulations reflect the predominantly practical-ethical or bioethical understanding of animals, i.e. the evolution of attitudes of legislators towards the environment, animal life as its integral part, and even towards animals as individual beings or creatures by themselves, their overall integrity and well-being. The meaning of such animal protection was, and still is anthropocentric in nature, since in its centre are not animals as such, but different interests of man and society as a whole, such as the protection of human health, economic development and development of various economic branches, animal husbandry, hunting, fishing, protection of public morality, order and good practice and feelings of man towards animals as well as the economic interests of animal owners.

In contrast to the Pre-Socratic concepts, modern legislations most commonly establish the basic principles of the protection of animal welfare on the so-called patocentric concept, because they speak of the "universality of pain", and besides the pain, suffering, fear and stress, it is usually added that animals can feel panic

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[32] Germany is the first country in the European Union, which based on an amendment to its Constitution from 2002 provided the highest standards of legal protection of animals at the federal level.

[33] Serbia adopted its Law on Animal Welfare in 2009. Animal welfare is usually, however estimated based on internationally accepted concept of the so-called "Five Freedoms". 1. Freedom from hunger and thirst: by ready access to fresh water and a diet to maintain full health and vigor, 2. Freedom from discomfort: by providing an appropriate environment including shelter and a comfortable resting area, 3. Freedom from pain, injury or disease: by prevention through rapid diagnosis and treatment, 4. *Freedom from fear and distress:* by ensuring conditions and treatment which avoid mental suffering, and 5. Freedom to express normal behaviour: by providing sufficient space, proper facilities and company of the animal's own kind.

as well. The truth is, however, that these conventions, protocols and laws, still do not recognize the fundamental “right” of animals to life. Regardless of the fact that the laws on the protection and welfare of animals are a “matter of public interest”, the majority of them, actually, do not prohibit any harm or damage inflicted to the health of animals, including their killing, but only forbid if it is done contrary to the provisions of the law. Article 15 of the Law on Animal Welfare of the Republic of Serbia, for example, lists nine grounds according to which animals can be deprived of life “humanely”, and in accordance with the law. This list includes item 3, according to which an animal may be killed for the purpose of being used as food. As long as modern societies remain largely associated with the consumption of meat, this basic “right” of animals may be only gradually implemented, and therefore anchored to the very fence of more specific legal regulations, of course with different programming of dietary and other habits of the new generations of man. It is highly unlikely that in the foreseeable future man will stop eating animals, i.e. that he will accept a fundamental “right” of animals to life, however that does not mean that we should not continue to work on deepening the protection of non-human living beings.

In other words, in order for the sensibility of animals to be adequately internalized it should become an integral part of the education of all from the earliest days. It is very important that the different authorities and the citizens themselves in their knowledge and insights do not go below achieved civilized standards of ethical-moral culture and to reflect on different topics concerning the relationship towards animals with due caution and awareness about the dilemmas they may encounter in their professional work and life. A suitable multi-perspective approach, as well as awareness about responsibility, should result in a more delicate and responsible treatment of animals by all mentioned. Finally, a reasonable care of the protection and welfare of animals does not mean that the author of this paper believes that animals should be entitled to a kind of “moral status”, which would be in conformity with human moral phenomenon. He, moreover, follows the traditional ethical view that moral status can belong only to man, since he is the only natural being that can act morally. After all, taking care of the “dignity” and all present and future “rights” and status of animals, as well as of deepening of their protection, is basically man’s task.

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THE PERSON, A MEANINGFUL NOTION IN BIOETHICS. A PHILOSOPHICAL AND THEOLOGICAL APPROACH

ADRIAN MĂGDICI[1]

REZUMAT. ***Persoana*, o noţiune cu tâlc pentru bioetică. O abordare filosofico-teologică.** Noţiunea contemporană de persoană, golită de fundamentul ontologic și axată pe fragilul atribut al raţionalităţii, în loc să le fie de folos fiinţelor umane lipsite de apărare, tinde să devină mai degrabă o subtilă unealtă eugenetică. În alte cuvinte, pe măsură ce dezinteresul faţă de dimensiunea metafizică a omului crește, graniţa dintre bioetică și thanatoetică devine din ce în ce mai lichidă, iar idea de persoană tot mai șubredă. Scopul reflexiei noastre, așadar, este acela de a încerca să redescoperim contextul originar în care s-a afirmat noţiunea de persoană și, prin urmare, sensul meta-fizic al persoanei, indispensabil pentru o antropologie sănătoasă și pentru o bioetică genuină.

Cuvinte-cheie: *persoană, bioetică, concepţie despre viaţă, materialism, hilemorfism, meta-fizică, teologie, Dumnezeu*

ABSTRACT. The contemporary notion of person, devoid of ontological basis and built on the fragile characteristic of rationality, is not useful in defending defenceless human beings. Instead, it rather tends to become a subtle eugenic tool. In other words, the less we are interested in the metaphysical aspect of human life, the more fluid becomes the boundary between bioethics and what we may call thanato-ethics, while the concept of person gets flimsier than ever. The goal of the following reflections is therefore to try to rediscover the original context which allowed full expression of the notion of person and, consequently, to rediscover the meta-physical sense of the human person, which is imperative for a healthy anthropology and a genuine bioethics.

Keywords: *person, bioethics, worldview, materialism, hylomorphism, meta-physics, theology, God*

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[1] *Assistant lecturer, PhD., The Franciscan Roman-Catholic Theological Institute, Faculty of Pastoral Theology, Roman (NT), Romania. Email: adypellegrino@yahoo.it*

Introduction

The word *tâlc* is defined in any Romanian language dictionary in terms such as: "meaning", "sense", "purpose", "significance", but also through the phrase "profound, hidden meaning", which opens way to the meaning of mystery. As for the Romanian adverbial phrase *cu tâlc*, one of its meanings is that of "allusion", which, in turn, refers to what cannot be directly understood, to what can be sensed only when it appears into a certain context. Thus, the purpose of this paper's title is to remind us that, on one hand, *the person* is a fundamental notion for anthropological reflection and that, on the other hand, the mystery surrounding this notion requires sustained effort to clarify its essence by rediscovering the original context in which it was affirmed: Christian theology (Ratzinger 1990, 439).

The Origin of the Concept of *Person* Promoted by Contemporary Society

Contemporary society, characterized by an unquenched thirst for consumption (Schwartz 2004, 70-75) and thus attracted in a dizzying chase after novelty, tends to perceive reality – objects, living beings, even human persons – as the results of fleeting accidents, like ripples crossing the global oceans. Entities seem so inconsistent that people feel dissolved (Levi-Strauss 1962, 326), lost in anonymity within a *fluid* world (Bauman 2000, 110-129), a world where "the liquid modern 'tyranny of the moment', with its precept of *carpe diem*" seems to replace the traditional *memento mori* (Bauman 2007, 104).

The world view fostered by a specific society inevitably includes a certain view on the human person, which, in its turn, will determine the type of bioethics adopted in everyday life. This means that "ethical norms are the fruit of a specific conception of man, and every conception of man is the fruit of a specific conception of reality, of existence in its totality" (Rovighi 1976, 216).

Yet, the ultimate purpose of the world does not present itself as *immediately* accessible to our mind, but it remains somehow "outside" the world itself (Wittgenstein 2001, 56), requiring, in order to be understood, a hermeneutics similar to the one proposed by St Paul: "At present we see indistinctly, as in a mirror, but then face to face" (*1 Cor* 13:12). Man, therefore, as long as he is endowed with the capacity to reflect upon himself, is bound to have a worldview, but the worldview he fosters implies a choice (Delumeau

2001, 18; Nagel 2012, 5-7, 42-47), a choice which will lead, as underlined above, to outlining a certain concept of human person and of bioethics. *The religious man*, no matter the historical context of his life, "always believes that there is an absolute reality, *the sacred*, which transcends this world". *The profane man*, on the contrary, "refuses all appeal to transcendence". He "*makes himself*, and he only makes himself completely in proportion as he desacralizes himself and the world" (Eliade 1957, 202-203).

The *de*-sacralisation of the person gained momentum in the 17th century, when *the person* was redefined on empirical basis:

> "To find wherein *personal identity* consists, we must consider what *person* stands for; which, I think, is a thinking intelligent being, that has reason and reflection, and can consider itself as itself, the same thinking thing in different times and places; which it does by that consciousness which is inseparable from thinking, and, as it seems to me, essential to it; it being impossible for anyone to perceive, without perceiving that he does perceive" (Locke 1801, 54).

David Hume, an empirical philosopher and adept of radical scepticism, deepened the *de*-ontologization of the person by advancing a doubt on the existence of the *subject*, the classical receptacle of experiences:

> "When I enter most intimately into what I call *myself*, I always stumble on some particular perception or other, of heat or cold, light or shade, love or hatred, pain or pleasure. I never can catch *myself* at any time without a perception, and never can observe anything but the perception" (Hume 1739, 252).

The same philosopher considered that "our idea of any mind is only that of particular perceptions without the notion of anything we call substance, either simple or compound" (id. 2007, 142).

Hume was certainly wrong, since "our idea of 'a mind' (if by 'a mind' we mean, as Hume usually does, a person, or a self) is not an idea only of 'particular perceptions'", but "it is an idea of that which loves or hates, and of that which feels cold or warm [...]". Therefore, our perceptions "are not entities in their own right; they are 'accidents'" (Chisholm 1969, 9, 17) requiring support (Farris 2012, 63), which means an "individual substance of rational nature" (Boezio 1979, 326). Yet, modern thinking has laid the basis of a mostly psychological (Harris 2001, 14-20; Rechlin 2008, 9), phenomenological and analytical concept of the person (Chisholm 1969, 7), a vision which will deeply influence contemporary anthropology (Parfit 1984) and especially bioethics (Fornero 2005, 87-89).

On the other hand, the 18th century, which brings affirmation of human rights, also sees a *re*-sacralisation of the person and this change in perceiving the sacred led to a reformation of the penal system (Joas 2013, 58). Sociologist Émile Durkheim, a zealous defender of human rights and universal human dignity, wrote:

> "The human person, whose definition serves as the touchstone according to which good must be distinguished from evil, is considered as sacred, in what one might call the ritual sense of the word. It has something of that transcendental majesty which the churches of all times have given to their gods. It is conceived as being invested with that mysterious property which creates an empty space around holy objects, which keeps them away from profane contacts and which draws them away from ordinary life. And it is exactly this feature which induces the respect of which it is the object" (Durkheim 1975, 61).

Nevertheless, afterwards, while modern empiric thought turned into positivism and neo-positivism, *the person* was again under attack, torn down from the pedestal of metaphysics and thrown directly on the dissection table of scientific reasoning. Thus, right after the Second World War, country delegates who, at the initiative of the United Nations, laid the foundation of the *Universal Declaration of Human Rights*, adopted "the meta-language of a universal secular order" (Arieli 2002, 8), with the purpose of avoiding disagreement on metaphysical and religious issues and obtaining consensus from peoples and cultures from all over the world. As the basis of human rights, they established *dignity*, an ambiguous and discriminatory Kantian concept (Schroeder 2010, 121) which, unlike the other two proposed – *God* and *natural law* (Pizzorni 2006, 478) – reflects an ethical vision (Kant 1991, 230) rather than an ontological position (Glendon 1999, 12-13).

The shudder of horror produced by the atrocities of the Second World War indeed required speeding the process of adopting the *Universal Declaration of Human Rights*, but, as it seemed impossible to reach a theoretical agreement, a practical one was preferred, which aimed at a practical outcome [international cooperation]. Philosopher Jacques Maritain, who had the leading role in drafting the *Declaration*, remembers:

> "At one of the meetings of a UNESCO National Commission where Human Rights were being discussed, someone expressed astonishment that certain champions of violently opposed ideologies had agreed on a list of those rights. 'Yes', they said, 'we agree about the rights but on condition that no one asks us why'. That 'why' is where the argument begins" (Maritain 1948, i).

Therefore, despite its powerful moral implications, the concept of *dignity* is elusive, lacks solid theoretical foundation (Di Pietro & Moltisanti 2009, 72) and some bioethicists consider it useless in medical practice

(Macklin 2003, 1419). But we shouldn't forget that ideas in our mind can be like a machete in the hand of a man lost in the jungle: they can help us survive and advance towards *the light*; they are an expression of our perseverance and strength. Finding among the flimsy words of human language a suitable concept to justify our faith in man's inalienable value is not only a matter of etymology, but of applied sense. In other words, why, unlike other living beings, we, humans, are so convinced we have dignity? (Brungardt 2011, 13) And the answer is, of course, none other than this: *Because we are human persons*.

But what is *the person*, this "*paradoxical reality*" (Mouroux 1953, 105), considered so sublime that it deserves to be infinitely worthier than any other entity in the whole universe (Baumann 2007, 7), while others consider it so earthly and subject to the vicissitudes of the evolutionary process that is hardly distinguishable from other animals like monkeys or dolphins? (DeGrazia 2006, 44; White 2007, 155-184)

Materialist thinkers (Dennett 1991, 33; see Lund 2014, 56 and BonJour 2010, 3, 5-21) don't see any difference – at least not an essential one – between the death of a man and that of an animal, because "the death of a person is the death of an organism". In other words, "the permanent end of consciousness, of intentionality, and of subjectivity is literally an organic disintegration of the person". Thinking differently "is to be dualistic" (Van Hooft 2004, 156). And, if one wishes to avoid being labelled like that, one must consider human beings from a strictly empirical point of view, assimilating it with a "biological thing" (Boklage 2010, 1) of the species *Homo sapiens* ["biological person"], an entity which, in order to be granted the statute of a "psychological person", needs a functioning brain and an intellectually and morally conscious mind (Feldman 1992, 119-120). And, taking into account that the Lockean definition of the person has become axiomatic for science (Harris 2001, 25; Müller 2011, 86), most bioethicists and medical researchers think that embryos, foetuses, anencephalics and those in a *persistent vegetative state* are not, or at least not anymore, *persons*, because they haven't formed their cerebral structures yet, or because these structures are insufficient, or because they have suffered irreparable damage to their cerebral cortex, which has made them irreversibly lose their cognitive capacity. But based on what principle can science decide whether a being is a *person*, since science is "only one system of investigation within that larger arena of human study of nature, persons, and society"? (Tauber 2009, 125) And who can guarantee that the Lockean definition of the *person* is correct? (Butler 1906, 257-263; Reid 2008, 113-118; Paterson 2008, 133-135)

The contemporary concept of the *person* (Beauchamp 1999, 319), just like the one of *dignity* (Thiel 2010, 51; Warnock 1983, 242), "is used in a variety of contexts" (Gregersen 2000, 1), seeming somehow "adjustable to the different requisitions of the philosophical pluralism which characterizes the bioethical debate". The thorny aspect of this *flexibility* however, is that "the notion of person, having been separated from its roots, is assigned today many roles which endanger its intuitive and original potential", which has paradoxically led to using it "'against' man himself" (Palazzani 2004, 1357). On the other hand, when shedding light on the person, one of the biggest temptations of contemporary man is to try and get the deep meaning of the concept by analytical methodology or through a strictly scientific approach, as if solving the mystery depended more on the propriety of terms or empirical knowledge than on reflecting about the inner aspect of the beings in question (Skrbina 2014, 220). Actually, the emphasis must be on the *meta*-physical origin of the *person* (Sesboüé 2002, 324), and the analytical and/or scientific method should come second, as it is only logical that its value will be determined by the answer somebody gives to the first question mentioned above (Weisstub & Thomasma 2001, 325-326). That is why we have preferred to postpone the traditional etymological analysis we should have begun with, but now we shall try and undertake this task.

The Mysterious Etymology of the *Person*-concept

The origins of this concept remain mysterious despite the numerous attempts to elucidate it (Milano 1996, 63).

First, in Ancient Greece, while the idea of person had not appeared yet, they used generic terms like *τις* [someone] or *ἄνθρωπος* [man] to refer to the human being. When they wanted to be more specific, they used words like *σῶμα* [body], *ψυχή* [soul] and *θυμός* [vital breath]; these principles make the actual human being (Nédoncelle 1948, 277) and – as shown in the Homeric poems – they also guarantee a double existence for the human being: one visible and limited, based on body [σῶμα] and vital breath [θυμός], the other invisible and immortal, based on ψυχή, which is subsisting soul (Rohde 1925, 6). Then came another term that was given priority: *πρόσωπον*, which means *face*. It is worth mentioning that this term will also be granted the meaning of *mask*, which was initially used in religious rituals and then on the stage, thus allowing both actors and participants to the sacred ceremonies to re-*animate* [personify] those who could not express themselves as real flesh-and-bone persons.

Ancient Romans also referred to the human being with generic words such as *is* [he, that one], *homo* [man], *caput* [individual], but also with terms like *corpus* [body], *anima* [soul] etc. Yet, unlike the Greek *πρόσωπον*, the Latin term of *persona* [mask] – which is instrumental to our analysis – is much more difficult to define from an etymological point of view, as it has seen a much more complicated semantic evolution (Nédoncelle 1948, 285). In the 2nd century AD, Latin scholar Aulus Gellius, following in the footsteps of grammarian Gavius Bassus and his *De Origine Vocabulorum* [a work now lost], considered that the term of *persona* was derived from the verb *personare,* since the mask [*persona*] entirely covers the face of the wearer and only lets the voice out thorough a single opening, the one in front of the mouth, which makes the voice clearer and more resounding (Aulus 1762, 391-392). There were other etymologies proposed later, although most of them are debatable, for instance the definition from Papias the Lombard's glossary [11th century], *persona dicitur quia per se sonat*, or the one from grammarian Pacidus' glossary [6th century], also mentioned by Thomas Aquinas, *persona eo quod per se una est*, or Giulio Cesare della Scala's hypothesis [1484-1558] according to which *persoana* comes from *περι-σῶμα*, in Latin *circum-corpus*, a phrase meaning "around the body" (Nédoncelle 1948, 286).

Finally, one of the most plausible hypotheses regarding the origin of the term *persona* seems to be the one leading to ΦΕΡΣΥ [*Phersu*], an Etruscan word written next to a representation of a masked dancing individual on a fresco from the grave named *Tomba degli Auguri*, discovered in the Italian region of Corneto-Tarquinia (Milano 1996, 64). This mysterious character, *Phersu*, most probably an Etruscan god of the dead, has led to *persona*, the mask Romans wore during the ceremonies for the dead [*imagines mortuorum* or *animorum*] (Ribas Alba 2011, 121-123). As a matter of fact, *persona* was not only the mask worn by the actors in the ceremony, but also "a support-representation of the deceased's soul" (Barcelo 2013, 308).

Is *Bioethics* a Meaningful Notion for the Person?

In the *Introduction*, when we explained the purpose of the title chosen for this article, we purposefully mentioned that one of the meanings of the Romanian adverbial/adjectival phrase *cu tâlc* is that of "in allusion to/alluding”, referring to something that cannot be fully understood outside of a certain context. That is why, before trying to see how the notion of *person* is meaningful [*cu tâlc*] for bioethics, we could wonder what really is *the meaning of bioethics* and whether *bioethics* is a *meaningful* notion for the person.

A few decades have passed since moral philosophers and medical science researchers realized that ethics, if not incarnated within bioethics, remains an arid and abstract reflection (Arras 1994, 983), risking to contradict its original essence, its *ethos*, its “abode, dwelling place” (Heidegger 1998, 269). Heidegger, reviving an anecdote mentioned by Aristotle, tells how some strangers who had wanted very much to meet the famous Heraclitus were totally disappointed when they saw him warming up by a baker’s oven just like ordinary people. They expected to find him lost in cogitation, detached of bodily needs. But the philosopher, aware of the people’s expectations, did not feel embarrassed, but invited them to join him, saying: “Here too the gods come to presence” (ibid., 270). *Ethos* therefore is revealing because, if we take into account the fact that the Heraclitean universe is divine, the value of each of its entities arises from its very ontological structure, just like the dignity of each human springs from one’s own *δαίμων*, which is one’s own divine feature. Actually, Heraclitus, also named The Obscure, would concentrate his own anthropological vision in an aphorism formed by only three words: ἦθος ἀνθρώπωι δαίμων, *the man’s abode is his own soul/conscience* (Robb 1986, 339-340).

Neo-positivism, though, adopting the so-called “Hume’s law” (see Hume 1739, 469), has established that morality cannot be deduced from empirical reality (Moore 1903, 9-10) and, although positivist ideology has collapsed, science still uses this old rule. This state of facts owes to the world vision shared by most of today’s scientists (Larson 1998, 313) – it is called *philosophical naturalism* – and on its basis notions like *person*, *dignity* or *the meaning of life* are considered mere fictions, impossible to categorize from an empirical point of view and without relation whatsoever with a hypothetical transcendent origin (Mitchell et al. 2007, 36-37).

But ethics embodied in bioethics is living proof that our real “abode”, the biosphere, is related to *ethos*. From this point of view, *ethos* is the laborious harmony between *micro*- and *macro*-symbiosis, a harmony imposing respect as it is our own harmony, too, the vital space and under-layer of human existence (Kauffman 2008, 259-272). Therefore, the conception saying that facts cannot convey values is groundless (MacIntyre 2007, 148-150); on the contrary, the simple fact that the *biosphere* is a complex network of symbiotic relations does represent, beyond all human considerations, a value in itself, because it guarantees life for all biological entities (Mashe 1975, 29-39). The simple fact that we come into the world with the “yuck factor” (Caulfield & Chapman 2005, 0737) incorporated and therefore we intuitively feel disgusted by torture, homicide and so on is revelatory enough proof that “morality isn’t a superficial feature of our world” (Copan 2008, 143). We are also convinced that, to be able to fulfil its purpose, especially when the human person is reduced to its biological aspect, bioethics needs a robust *meta*-bioethical foundation, not only through more cohesive interdisciplinarity, but also from a *meta*-physical point of view (Russo 2004, 737-739). And the Boethian concept of *person* subscribes to this very *meta*-physical point of view (Marenbon 2003, 72).

The *Meta*-physical Concept of Person and Its Relevance for Bioethics

The classical definition of the *person* by Boethius – *naturae rationalis individua substantia* [*individual substance of rational nature*] – since it does not take into account the human being, having as purpose to clarify some aspects of the Trinity (Forrest 2003, 75; Buchanan 1962, 21) and of Christology, ignores man’s corporality (De Monticelli 2006, 4-5). St Thomas Aquinas realizes that the Boethian definition lacks any reference to corporality and, wanting to fight the spiritualist trend of his own age, amends it:

“For person in general signifies the individual substance of a rational nature. The individual in itself is undivided, but is distinct from others. Therefore person in any nature signifies what is distinct in that nature: thus in human nature it signifies this flesh, these bones, and this soul, which are the individuating principles of a man, and which, though not belonging to person in general, nevertheless do belong to the meaning of a particular human person” (*Summa Theologiae*, I, q. 29, a. 4 co).

A few pages before in his *Summa*, St Thomas mentions:

“The soul is a part of the human species; and so, although it may exist in a separate state, yet since it ever retains its nature of unibility, it cannot be called an individual substance, which is the hypostasis or first substance […]; thus neither the definition nor the name of person belongs to it” (ibid., I, q. 29, a. 1 ad 5).

St Thomas’ thinking, though, can leave us perplexed (Quinn 2004, 88-89): if it is true that the soul, after a man’s death, is neither **hypostasis** [individual substance], nor **person** [*individual substance of rational nature*], then what is it? Is it an attribute, an accident? (Amerini 2009, 72; Kenny 2004, 28) Can an *attribute* subsist without any individuality/consistency/substantiality whatsoever? (Oaklander 2001, 185) If the soul separated from the body is neither *person*, nor *individual substance*, then what are ***those who***, according to Catholic doctrine, "still have need of purification to enter into the happiness of heaven"? (CCCC 2006, no 210) In this case, there are two possibilities: either the human soul possesses a special intellect (Wippel 2002, 114-140) – different from the *synaptic* one (LeDoux 2002) – and therefore it is personal *meta*-physical conscience (Spencer 2014, 863-912) which allows it to subsist after death (Eben 2012, 85) [even if normally it exists as a *human* person], or it has no individuality – no personality and, in this case, it disintegrates together with the deceased's body (Kenny 2004, 28).

The only way to solve this dilemma is to admit that the separated soul is essentially a *person* ["minimal-person" (Helm 1978, 16)], similar to bodiless intellectual beings [God and the angels] (Marenbon 2003, 72), and that, in this hypostasis, it tends to regain what is essential to its *humanity*. Actually, in a document of the *Holy Congregation for the Doctrine of Faith*, St Thomas Aquinas' hylomorphic definition of the *person* is challenged: "Temporal life lived in this world is not identified with the person. The person possesses a level of life that is more profound and that cannot end" (SCDF 1975, no 9).

Human person is certainly, as it results from different theological affirmations (Giovanni P II 1986, no 3-5; CCC 2003, no 362), *a dual unity*, but this *duality* actually does not concern those who belong to the *person* "genus" [God, angels] (Murphy 2008, 57; McArdle 2006, 5), but rather one of its "species", the *human* one (Lund 2009, 13). Therefore, from an anthropological point of view, dual is not the *person*, but the man, who, in addition to his natural bio-psychological configuration, is also supernaturally imbued by a *meta*-physical ego whom we shall name *personal immortal soul* (Masset 1983, 321, 339).

Both science [through discoveries confirming evolution] and faith [thanks to Christology] force us to consider human individuals from different perspectives, one natural, due to man's bio-psychological configuration, and one supernatural, taking into account his immortal soul. Therefore, when we say *human person*, we refer to an entity which is part of the *human* bio-psychological species, is inclined to develop a spatial-temporal mind [conscience] (Corradini 2008, 205-206; Holmes 2005, 15) and, from the very first moment of its activation in a human sense, has been endowed with an immortal *meta*-physical ego. The two aspects, material [bio-psychological] and spiritual [*meta*-physical] (see Possenti 2014, 28; Zimmerman 2011, 168; Casey 2011, 342-343; Lewis 2007, 37) forces us to keep our distance from Tomist anthropology (see *Summa Theologiae*, II-II, q. 64, a. 2, ad 3; Blazquez 1983, 284, 287, 290).

The first motive of our reticence regarding Tomist doctrine of the *rational-immortal-configurator* soul (Eberl 2006, 5, 8-9) owes to the fact that *this*, if we seriously consider the phenomenon of evolution, should evolve together with the matter that it configures (Hasker 2011, 210), a hypothesis which has not been accepted by the Magisterium of the Catholic Church (Giovanni P II 2009, 355).

The second reason for our reticence to Tomist hylomorphism is related to Christology. Different magisterial documents show that "only in the mystery of the incarnate Word does the mystery of man take on light" (Paolo VI 1985, no 22; CDF 2011, no 7). In the incarnate Word there must be something which is also in us (Sesboüé 2002, 322, 334), and finding that *something* should enlighten us. Just like the incarnate Word, through His humanity, is the visible hypostasis of the invisible God [one of the Holy Trinity's *Persons*], just the same, or in any case similarly, the human being, through one's [bio-psychological] body, is the visible hypostasis of the immortal personal soul, which is invisible; and this truth becomes ever more obvious when we take into account the fact that "at its roots, the notion of person is imbued with theology" (Palazzani 1998, 56; Zizioulas 1997, 27). Therefore, by the incarnation of the Word, God – as unlikely as it may seem (Nagel 2012, 26) – knows all the vicissitudes of natural order despite the fact that, being part of the eternal communion between the Holy Trinity's Persons, is not governed by natural law, thus suggesting that the *person* is not an essentially *hylomorphic* [informed matter] or empirical reality.

An example as conclusive as is possible in this direction is the definition of the *person* made by theologian Richard de Saint-Victor – "divinae naturae incommunicabilis existentia" – *incommunicable existence of divine nature* (De Saint-Victor 1958, 187) – a definition which reflects a profound *meta*-physical intuition. But this intuition has not been accordingly valued by Christians:

> "Scholastic theology developed categories of existence out of this contribution given by Christian faith to the human mind. Its defect was that it limited these categories to Christology and to the doctrine of the Trinity [...]. This seems to me also the limit of St. Thomas in the matter, namely, that within theology he operates, with Richard of St. Victor, on the level of existence, but treats the whole thing as a theological exception, as it were. In philosophy [...] he remains faithful to the different approach of pre-Christian philosophy" (Ratzinger 1990, 449).

Thus, if the Persons of the Holy Trinity and especially that of the incarnated Word are considered as "theological exceptions", which do not tell anything in relation to our *meta*-physical status, and similarly, if the Person of the eternal incarnated Word – Who has become a human individual from the moment of conception – does not say anything about our human individuality, then by what else could the incarnate Word illuminate us?

In our opinion, *the person* – and Christology confirms this – is not an immanent naturalistic category (Caspar 1991, 408-411), but a *meta*-physical ego (Mauss 1938, 278). In fact, from a historical point of view, we have not started from the idea of "man" to get to that of "human person" and "divine person", but, on the contrary, we have started from the idea of "divine person" to establish the parameters of the "human person" and, therefore to see whether these parameters are still compatible with those that science uses about man today (Bertagna 2006, 51-52).

Paradoxically, the hylomorphic concept of *person*, although it was founded by St Thomas Aquinas to fight the spiritualists who despised the body, due to some Aristotelian inadvertences (Müller 1996, 21-26; Gardel 2012, 4165), has today become an argument for philosophers and bioethicists willing to justify various crimes against human being, especially against those human beings who are either in an incipient or in a final stage of their existence (Glannon 2000, 49-69).

Conclusion

The hylomorphic concept of the *person*, subordinated to Aristotle's philosophy and therefore the fruit of an immanent vision (Wojtyla 1978, 108-109), is an "affront to human dignity" (Shostak 2006, 1). In the context of contemporary physics and biology, hylomorphism is rather an outdated attempt to describe a complex variety of entities – with their gradual transition-evolution from pure materiality to more and more bio-*logical* specifications – through a cliché like the concept of *form* (Shields 2007, 293; Williams 2006, 225-226) and through a disturbing procession of vitalist *souls* (Dupre 2002, 155; Mariani 2003, 98; Bennett 2010, 56; Amerini 2009, 37-38). And, since the origin of "the modern crisis of the concept 'person' lies in the crisis of Christianity and of traditional metaphysics" (Zaborowski 2010, 183), the rediscovery of the forgotten sense of the person can only be done by "destroying the zoological understanding of the human person" (Housset 2007, 18). We should not, therefore, confuse the metaphysics of the world, in which man takes part as a biological individual (Mauron 2002, 958-959), with the supernatural *meta*-physics in which the *person* takes part (Bonaventura 2012, 97, 99). If we accept a two-layered ontology, similar to the one which governs Christology, many bioethical thorny issues could be solved much more easily. That is why, in our opinion, the *meta*-physical concept of *person* is much more desirable than the hylomorphic one, since it is much easier to manipulate the latter in bioethical debates.

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ETHICAL APPROACHES IN RESEARCH PRACTICE

DEJAN DONEV[1]

REZUMAT. Abordări etice în practica cercetării. Standardele înalte ale eticii conferă o calitate mai înaltă cercetării și crește, în mod substanțial, impactul său social. Se promovează integritatea cercetării și o mai bună aliniere a cercetării la nevoile și expectanțele comunității. Intenția autorului acestui articol este de a determina poziția actuală și aplicarea abordărilor etice curente în practica cercetării, în termenii dezvoltării spațiului internațional de cercetare comun cu un „standard universal armonizat și transparent" pe teritoriul european.

Cuvinte-cheie: *etică, cercetare, abordări, teritoriu european*

ABSTRACT. High standards of ethics provide a higher quality of research and increase substantially its social impact. They promote research integrity and better alignment of research with community needs and expectations. The author's intention is to determine the current position and the application of the current ethical approaches in research practice in terms of the development of common international research space with a "transparent and universally harmonized standards" on European soil.

Keywords: *ethics, research, approaches, European soil.*

Introduction

As a result of the indolent behaviour of man in different fields of life, the time in which we live today is characterized by a number of unresolved problems which as an increased storage gained pulled with decades and decades. Among many of them science, particularly research, but mostly the application of scientific research, are been a subject of special interest.[2]

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[1] *Assoc. Professor, Centre for Integrative Bioethics, Kumanovo, R. Macedonia, Email: donevdejan76@gmail.com*

[2] On which point out even Edward Diener & Rick Crandall, *Ethics in Social and Behavioural Research*, University of Chicago Press, Chicago, 1978, as well as Lucinda Peach, "An Introduction to Ethical Theory", in Robin Levin Penslar (ed.), *Research Ethics: Cases and Materials*, Indiana University Press, Bloomington, 1995, pp. 13-26.

In this domain of human existence and activity the history has shown that even the best intentions do not always have a good result and effect, therefore, in the context of morality and ethics, a change and expansion of the areas of morality was made, by which besides classical, according to which attitude towards self was and still is the primary, the expansion has come in terms of relationships with others, toward community, nature, life.... Logically, a change in the leading ethical theories was made, so instead the reason of Abelard as an initial in ethics assessment, now we seeks for consequence to be key stone, a criteria according to which the moral and ethical intention and action will be evaluated and in science a literal example was the research with atomic energy, which ultimately resulted in the massive extermination and destruction of the human race.

Current Situation

Hence, in the last 30-40 years we are striving again to bring ethics in scientific research, normative ethics, not only as a regulator and "ultimate judge" of what we are doing and applying, but at the same time as an incentive for developing ethical awareness and conscience, so that terrible consequences can be avoided in the future. The idea is primarily "to achieve four things", "to show the practical value of the serious and systematic thinking about what is ethical conduct in research", move over "to determine how and why the currently existing systems of regulation occurred", simultaneously to get to the "clearing the field and identifying those practices that led to antagonism between researchers and regulators "and to make "encouragement for both sides jointly to devise solutions to ethical and regulatory issues"[3].

The same result from "loosening of moral reins" due to the social changes that have taken place, then for a whole series of specific causes and events, and also the growing social fragmentation and decline of it about the intensity of social life and public engagement, for which in general terms, most blame was put on the change in and on cultural process and pattern which emerged and developed thanks to Postmodern. Accordingly, as emphasized Bauman, rules "distrust toward the metanaration"[4], resulting in the rejection of the possibility of universal, ethical based norming, or a point of departure is the final debate on the authoritativeness of the definitions and one dimensionality of narratives[5]. Even more rigid, ethics is what in the light of postmodern relativism is understood as something that is "designed for the dump of history"[6].

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[3] Mark Israel & Iain Hay, *Research Ethics for Social Scientists*, SAGE, London, 2006, pp. 20.

[4] Zygmunt Bauman, *Postmodern Ethics*, Blackwell, Oxford, 1993.

[5] Andrew Sayer & Michael Storper, "Guest Editorial Essay", *Environment and Planning D: Society and Space*, vol. 15, No.1, 1997, pp. 1-17.

[6] Zygmunt Bauman, *Postmodern Ethics*, Blackwell, Oxford, 1993, pp.2.

But, since Postmodern made the biggest "sin" in all fields of human existence and action, breaking its individuality and uniqueness by deleting its authenticity and introducing the ethical relativism on a big door - the request for the return of ethics and ethical, even in research, at least vividly demonstrates the concern of man to his presence, but more importantly, to his future, in the attempt to find again its own essence, meaning and purpose of existence. It shows in the area of research, that scientists trying to think about ethical causes and consequences of their research, at the same time take care of ethics by trying through her to make sense of the existence and validity of their results. That is why the physicist Carl Friedrich von Weizsäcker pointed out that the degree of moral maturity scientists should be measured according to productive responsibility for the consequences of their findings which they practically take.[7] The same derives from the knowledge of the high ethical standards that ethics offers, and which have higher quality in researches, by which the social impact of the research greatly increases because they promote research integrity and better align research with societal needs and expectations.

Ethical Approaches in Research Practice

The idea is very clear and precise, and consists in the finding and re-acceptance of morally legitimate reasons that require that the research be subjected to an ethical evaluation according to the system of ethical judgment, because it is essential to identify the potential benefits and risks, that appear as a result from the survey's result, and whose main characteristic is the uncertainty.[8] Hence, it is essentially important to adopt the position that any research is not intrinsically ethical dubious in its basis, because despite the problems that arise during its implementation, there are a number of reasons why it should be supported and it should be seen as a valuable activity. Among these reasons one can mention:

- "the research brings a better quality of life and increases welfare;
- a number of lives can be saved;
- knowledge can be good therefore from itself"[9].

These reasons support two different types of justification for the investigation. "The first is an ethical argument - out intrinsic valuable - which is built

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[7] Carl Friedrich von Weizsäcker, *The Unity of Nature*, Farrar Straus Giroux, New York, 1980.

[8] Lisa Bortolotti & Bert Heinrichs, "Delimiting the Concept of Research: An Ethical Perspective", *Theoretical Medicine and Bioethics* 28, No.3, 2007, pp. 157-179.

[9] European Commission, *Europian Textbook on Ethics in Research*, Publications Office of the Europian Union, Luxembourg, 2010, pp. 14.

on the idea of knowledge resulting from good science"[10] and according to which the research is valuable, useful because of the benefit of knowledge that is implemented in the society. "The second argument relates to the idea of knowledge as intrinsic value, i.e. it in is valuable in itself regardless of any future benefits that might arise from its application"[11].

At the same time, these two differently based types of justification for conducting research in natural and social sciences, and their methodology of research, have different weight and importance. It is so because in the social sciences, the issue of choice and moral responsibility is heavier because their methods do not have that degree of valued neutrality, i.e. the ideal of objectivity, as in the natural sciences. Here is, already very difficult to make the distance between the researcher and the subject of research which keep objectivity, which necessarily raises the question of freedom in the activities of human life as a key assumption about the meaning of his life and value. It can be said that in social science, the problem of ethical evaluation of the research is complicated by the question of the articulation of freedom and its borders because in these studies is not possible avoidance of using individual human and social parts, as a material on which the research is conducted. In other words, research can, but it has to especially be methodologically ethical, not only scientific.[12]

The previous introduces us not only into the issue of intent, but also into the expected and possible consequences of the research, i.e. the potential benefits involved in terms of researchers and the general public, as well as risks in relation to the same participants. It is about the ethical framework of research and applied ethics, "which explores the ways possible to apply normative ethical theory to specific problems or specific situations or circumstances"[13], in this case in the field of research.

One of the ways to assess specific research is to identify, quantify the potential benefits and risks as to determine whether the consequences are good or bad, that is, focusing solely on the act - teleology approach. In terms of focusing on the act, also applies the deontological approach, which also represents one of the most important and leading approaches in ethical assessment of Western thought in the last hundred years.[14] As a third type of approach, the ethics of virtues can be

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[10] Ibid.

[11] Op. cit., pp. 15.

[12] Angus Dawson & Steve Yentis, "Contesting the Science/Ethics Distinction in the Review of Clinical Research", *Journal of Medical Ethics* 33, 2007, pp. 165-167.

[13] Piter Singer (ed.), *A Companion to Ethics*, Blackwell, Oxford, 1993.

[14] Nancy Ann Davis, "Contemporary Deontology", in Piter Singer (ed.), *A Companion to Ethics*, Blackwell, Oxford, 1993, pp. 205-218, kao i Lucinda Peach, "An Introduction to Ethical Theory", in Robin Levin Penslar (ed.), *Research Ethics: Cases and Materials*, Indiana University Press, Bloomington, 1995, pp. 13-26.

taken, which focuses on the ethical/moral agent, i.e. on the one that brings the decision and its motives and intentions. Also, there is still the principalism, that is quite significant, that focuses also on the acts, then the casuistry, ethical relativism and ethics of care.

According to the first one of the previously mentioned, i.e. its basic version and thesis, "morality of the action is completely definable in terms of its consequences, not the intent or motivation that might underlie the action"[15]. It is called consequentialism, and according to it, a particular procedure can be considered justified or morally binding if "produces the best possible relationship between good and evil in favour of the first"[16], meaning that "moral status of a particular procedure is determined by estimating the ratio of its good and bad consequences"[17]. If the positive effects resulting from any act or action outweigh the risks of not acting or acting in a different way, the same procedure may be morally desirable or defendable. Simultaneously, the most notable observations that point to this approach, refer to the fact that it takes only consequences as the only relevant factor, which consequently leads to neglecting the interests of individuals.

Under the second approach, according to critics indicated to the consequencialistic, the deontological approach developed as an alternative, indicating that the correctness or wrongness of actions is not determined by their consequences, but is determined by the nature of the action. In this context, "a thing can be considered morally right or ethically binding even when is not bringing the best possible relationship between good and evil, because according to this approach, the relationship between good and evil for the individual or the community, is not a sufficient basis for determining whether certain behaviour is moral or ethical"[18], which means it is necessary to take into account other consequences as well, not just those outmoral, i.e. certain acts are good by themselves, emphasizing above all the duty or doing what is right, regardless of consequence.[19] In other words, "consequentialism encourages us to strive for good and deontology encourages us to lead by example"[20]. At the same time, this absolutist approach to ethics is observed because of this inflexibility, and the lack of resolving an issue of conflict of different rights or duties.

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[15] Дејан Донев, *Етика во новинарството*, УКИМ, Скопје, 2011, стр. 146.

[16] Constance Holden, "Ethics in social science research", *Science*, Vol. 26, 1979, pp. 537, as well as Thomas I. White, *Right and Wrong: A Brief Guide to Understanding Ethics*, Prentice-Hall, Englewood Cliffs, New Jersey, 1988.

[17] Mark Israel & Iain Hay, *Research Ethics for Social Scientists*, SAGE, London, 2006, pp.34.

[18] Op. cit., pp.36.

[19] Дејан Донев, *Етика во новинарството*, УКИМ, Скопје, 2011, стр. 145-146.

[20] Philip Pettit, "Consequentialism", in Piter Singer (ed.), *A Companion to Ethics*, Blackwell, Oxford, 1993, pp. 231.

Because of this, in ethics there are offered at least two different approaches. One of them is called ethics of virtues, an approach that “addresses ethical issues within the character of the one who acts”[21], i.e. emphasizes the moral character of the makers of ethical decisions, not the consequences of their actions, or rules or duties under which they are managed. This suggests that despite the consequencialistic and nonconsequencialistic approaches in ethics which aim at the act, the ethics of virtue is an approach that focuses on the moral agent/the doer[22]. The same is commonly used if terms of questioning the nature of the doer or the motives under which he operates. It shows that the essence of ethics of virtue consists in the fact that the character is a primary object of ethical assessment, i.e. actions are warranted by what we say about the character of the doer. This derives from the basic idea, that the virtues are those character traits that lead to human development, while evils are the character traits that destroy that development. But as with the previous two approaches, the ethics of virtues faces certain objections, i.e. it is possible the appearing of relativism in terms of what is considered a virtue and choice. Another note refers to this ethics, is that does not give us a clear picture of what you need to do, but just tell us what kind of person we should be.

The second, which is also not focused on the act, is the ethics of care, whereby the focus is directed towards the care, compassion and human relations. It appeared late 70s of the last century and is associated with the name of Carol Gilligan, while her thesis is complemented by Annette Beyer, Virginia Held, and Nell Nodding. According to Gilligan, the conventional emphasis on the rights and obligations of Ethics are doubtful, as they are based on the understanding of masculinity[23], which creates two ethical ways of thought: the first, based on the ethics of justice and rights, mainly used by men, second, based on the ethics of virtues, which mainly use women applying the ethics of care that emphasizes interpersonal relationships, context and meaning of education.[24] In other words, “this approach is based on the criticism of consequentialism and deontology, which take ethical obligations as impartial and universal, denying them because they are based on unrealistic view of individuals as autonomous, self-sufficient being - they should be seen as social beings, with a complex set of relations”[25]. Therefore, this same principle was later criticized, particularly because of the lack

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[21] James Rachels & Stuart Rachels, *The Elements of Moral Philosophy*, McGraw-Hill, New York, 2009, Chapter 12.

[22] Lucinda Peach, “An Introduction to Ethical Theory”, in Robin Levin Penslar (ed.), *Research Ethics: Cases and Materials*, Indiana University Press, Bloomington, 1995, pp. 13-26.

[23] Дејан Донев, *Етика во новинарството*, УКИМ, Скопје, 2011, стр. 149.

[24] Marylon Friedman, “Liberating Care“, in *Feminist Ethics*, Moira Gatens (ed.), Ashgate, Dartmouth, 1998, pp. 543-584.

[25] European Commission, *Europian Textbook on Ethics in Research*, Publications Office of the Europian Union, Luxembourg, 2010, pp. 26.

of a central moral principle, “expressed underestimation of Kantian universal rules, impartial utilitarian calculation and individual rights”[26]. Still this ethics does not imply complete rejection of all other ethical approaches.

In addition to this range of ethical approaches in research, although in the Western normative ethics the emphasis is on consequencialistic and deontological approaches, as well as the ethics of virtues, there are also several approaches called principalism that focuses also on acts, then casuistry and ethical relativism.

Principalism known in England as “the system of ethics based on the four moral principles” was developed in the 1970s[27]by the American bioethicist Tom Beecham and James Childress, whereas it was expanded by the English scientist Raanan Gillon in 1994.

It is based on prima facie principles[28], i.e. respect of autonomy (the obligation to respect the ability of reaching a decision of autonomous personalities), beneficence (the obligation to do good and to balance benefit despite the risks) non-maleficence (obligation not to do harm, as well as justice (obligation to respect social distribution of benefits and burdens) according to which, asserting it provides response to moral pluralism, an accountability and simplicity are guaranteed to ethical resolution, independent of “deep epistemological and theoretic loyalties”[29].

It refers to an approach created in relation to the need of practical and “objectively transparent”[30] ways of reaching ethical decisions in times when the state starts to intervene in the field of ethics, i.e. in 1970s and the intention of introduction and application of arguments of utilitarianism and deontology in the field of decision-making and formulation of rules in the clinical practice.

However, as many other approaches in ethics, this one as well, according to criticism, suffers a lack of theoretic foundation, extended practice of western methodology, tendency to obstruct real ethical research and reasoning through the absence of a simple formula for conflict resolution as well as open individualism – in the course of the 1990s it goes out of fashion, especially due to the appearance of other approaches in ethics, above all the feminist ethics.

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[26] Tom L.Beauchamp & James F. Childress, *Principles of Biomedical Ethics*, 5th edition, Oxford University Press, New York, 1994, pp. 369.

[27]Product that has been developed thanks to the Belmon Report, the American report of ethical behaviour in research, publishen in 1979 – National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research*, 1979. http://ohsr.od.nih.gov/guidelines/belmont.htlm.

[28] Term introduced by the English philosopher Sir William D. Ross and under which it is understood that certain principle is normative until it is in a conflict with some other principle, when it is necessary to make a choice between the two of them.

[29]John H. Evans, “A sociological account of the growth of principalism“, *The Hastings Center Report*, Vol. 30, No. 5, 2000, pp. 33.

[30]Op. cit., pp.35.

Casuistry is an approach in normative ethics based on situation evaluation whereas we arrive to a principle via specific cases and challenges, and not vice versa, i.e. through cases and analogy, and not a consequence or principle, we try to define and clarify the "essentially vague ethical principle, such as "do not lie", or "return what you have borrowed" that we use as leading principles in practice.[31].

In this direction, researchers reach conclusions on ethical issues by drawing principles of similar, less problematic dilemmas and then apply them while resolving complicated issues,[32] i.e. causalistics points to paradigmatic cases that everyone agrees upon.

Ethical relativism is a theory implying that "ethical principles or judgments are relative to the norms of one's culture"[33], hence, whether an action is right or wrong depends on the moral norms of the society in which it is practiced, thus it is very inappropriate to ask from the researchers to follow the values that apply in a certain society.

But although the ethical relativism scoops its force from the observation that different types of people in society stick to different moral principles and practices that are largely conditioned by the cultural context, this approach has been widely criticized due to the stance that every moral principle is equally correct.

Instead of Conclusion

However, it does not seem so unreal to expect fast development of supranational, and, moreover, international approach on the research ethics part besides the current diversity of local approaches. Simply, the unsolved issues, and the pace by which we are trying to demonstrate an initiative in their solving, the same as the intention and the 'behind it', in a Jonas way expressed, will contribute to faster bringing to senses and dynamics. This particularly may be seen via the first initiatives, such as RESPECT or EUREC, or via unilateral initiatives coming from the USA. All these point out to some early development of the establishment of an international research ethics through the American 'common' rule, the same rule many found impossible to become 'common' at one time.

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[31] David Thacher, "The casuistical turn in planning ethics", *Journal of Planning Education and Research*, Vol. 23, 2004, str. 271.

[32] Lucinda Peach, "An Introduction to Ethical Theory", in Robin Levin Penslar (ed.), *Research Ethics: Cases and Materials*, Indiana University Press, Bloomington, 1995, pp. 13-26.

[33] Hugh LaFollette, "The truth in ethical relativism", *Journal of Social Philosophy*, Vol. 22, 1991, str. 146.

This means that if in the past the responsibility was seen through the prism of the old principle of interest for human fate, now the difference is huge because the interest for the human fate as a close goal has expanded in space and time due to the technical practice! It resulted in the gap between the strength of knowledge and power of act. This imposed the obligation or the expanded dimension of ethics to teach the more and more necessary self-control of our powers, i.e. to teach about the new understanding of the rights and obligations, something the former ethics has said very little about. Hence, the problem regarding the responsibility has come out to surface again, but this time in a new light and tackling new issues – not only human good is sought after but the good of out-of-human things, i.e. the recognition of the goals themselves to be extended via the human sphere, and the concern for them to be included in the term human good, which means the term of obligation to be extended.

Consequently, the change of the essence of people's acting, their powers, strengths and projected goals, and the current and possible results from their acting, also radically change the essence of the tasks of their ethic thoughts and actions. Instead of the former axiom – *Humanity should exist in future as well!,* the same should give way to the new categorical imperative – *Act in a way that will allow the results of your actions become adequate for the stability of the real human world on the Earth!*

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(RECOMMENDED CITATION)

THE REPRESENTATION OF DISEASE AMONG THE ROMA POPULATION IN NORTH-EASTERN ROMANIA

CAMELIA SOPONARU[1], SUZANA SEMENIUC[2],
BEATRICE-GABRIELA IOAN[3]*, MAGDALENA IORGA[4]

REZUMAT. Reprezentarea bolii în rândul populației rome din regiunea de nord-est a României. În condițiile noilor provocări ale globalizării, grupul etnic al Romilor, considerat pe plan internațional o minoritate dezavantajată, la limita subzistenței, indiferent de țara de rezidență, este un permanent subiect de studiu în variate domenii științifice. Unul dintre domeniile reprezentative pentru viața de zi cu zi, pe care se axează această lucrare, este cel al bolii și, implicit, al sănătății. Studii anterioare care au abordat aceeași problematică, sugerează că dacă în trecut reprezentarea socială a sănătății și bolii în rândul Romilor era profund impregnată de tradiții și tipul de gândire magică atât de caracteristic acestei etnii, în prezent a suferit modificări majore. Mai exact, explicațiile științifice ale bolii au luat locul celor mistice, și încrederea în practicile de vindecare tradiționale a pierdut teren în fața procedurilor medicale. Cercetarea de față a urmărit, pe de o parte, să identifice reprezentarea socială a bolii în rândul populației Rome și, pe de altă parte, să stabilească dacă aceasta a suferit modificări importante în ultimii ani, sub presiunea reprezentărilor sociale ale sănătății și bolii în rândul populației majoritare. În urma analizei rezultatelor interviurilor realizate putem concluziona că deși multe elemente ale nucleului central al reprezentării sociale sunt menținute, cum ar fi boala privită ca pedeapsă divină, superstițiile, metodele tradiționale de vindecare sau amprentele gândirii magice, se poate constata pătrunderea unor noi elemente în limbajul curent: cauzele bolilor din registrul medical, diagnostic sau tratamente medicale. În plus, un aspect important este modalitatea în care a evoluat relația medic-pacient, în prezent fiind aproape complet eliberată de constrângerile impuse de credințele tradiționale.

***Cuvinte-cheie**: boală, sănătate, Roma, tradiție, aculturație*

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[1] *PhD, psychologist, Associated Professor, "Al. I. Cuza" University of Iasi, Romania, puzdriac@yahoo.com*

[2] *Clinical Psychologist, Socola Psychiatrical Institute of Iasi, Romania, suzanachelaru@yahoo.com*

[3] *PhD, MD, associated professor, "Gr. T. Popa" University of Medicine and Pharmacy, Iasi, Romania*

** Corresponding Author: ioanbml@yahoo.com*

[4] *PhD lecturer, psychologist, Department of Behavioral Sciences, "Gr.T.Popa" University of Medicine and Pharmacy, Iasi, Romania, magdalena.iorga@umfiasi.ro*

ABSTRACT. In the context of the new challenges of globalization, the Roma ethnic group, internationally considered a disadvantaged minority, at the edge of subsistence, regardless of the country of residence, is permanently a topic of study in various scientific fields. One of the representative fields of everyday life on which this paper focuses is that of disease and, implicitly, that of health. Previous studies having tackled the same problematics suggest that, if in the past the social representation of health and illness among Roma people was deeply impregnated with traditions and with the type of magical thinking so characteristic of this ethnicity, at present, this social representation has undergone major changes. More exactly, scientific explanations of disease have taken the place of mystical ones, and the trust in traditional healing practices has lost ground to medical procedures and medication. The research has set out, on the one hand, to identify the social representation of disease among the Roma population and, on the other hand, to establish whether this has undergone important changes in recent years, under pressure from social representations of health and disease among the majority population. Following the analysis of the carried out interviews, we may conclude that, though many elements of the central nucleus of social representation are maintained, such as disease regarded as a divine punishment, superstitions, traditional healing methods or marks of magical thinking, one notices the penetration of new elements in everyday language: causes of diseases from the medical register, diagnoses or medical treatments. In addition, an important aspect is the way in which the doctor-patient relationship has evolved, currently being almost totally freed from constraints imposed by traditional beliefs.

Keywords: *disease, health, Roma, tradition, acculturation*

1. Introduction

In the context of the new challenges of globalization, the Roma ethnic group, internationally considered a disadvantaged minority, at the edge of subsistence, regardless of the country of residence, is permanently a topic of study in various scientific fields. From researchers in the medical field to sociologists and psychologists, everyone has been trying to sketch a portrait as complex as possible of the Roma ethnicity, one of the factors determining this interest from the scientific community being the very large difficulties faced by Roma people in the process of acculturation and, implicitly, in the integration into other majority groups. These difficulties are ascribed, on the one hand, to discrimination by majority populations and, on the other hand, to Roma people's resistance to change. This resistance to change has led researchers in the field of social psychology toward a more detailed analysis of Roma people's perceptions, attitudes and, ultimately, social representations of various representative fields of everyday life, and of the difficulty or ease with which these change as a response to present challenges. In other words, the way in which Roma people see the world and relate to it has aroused real interest.

The theoretical framework of research

Serge Moscovici's theory of social representations underpins the theoretical model on which this research has been structured. Thus, by *social representation* we understand "a structured set of values, notions and practices related to the object, aspects or dimensions of the social environment, a socio-cognitive system permitting the survival of the individual in society, channelling behaviours and communications, as well as selecting responses to environmental stimuli" (Neculau A., Curelaru M., 2003). Scholarly literature makes reference to three main components of social representations, corresponding to the cognitive, affective and behavioural register. The cognitive component of social representations is practically the most important of the three, because without cognitions there would be no representation. Moscovici claims that social representation also plays the role of reducing the individual's psychological discomfort created by his confrontation with new things, as it transforms the unfamiliar into the familiar. Hence the affective component of social representation. The third and last component of social representation is the behavioural one. Among the functions of social representation, we note that of orienting the individual. From this perspective, the term "conditional scheme" steps into the theory of social representations; it was introduced by Flament and it entails the prescription of the way in which an individual reacts to a certain situation.

Thus, "the transformation of representations is connected to accompanying practices. A change in practices generates a modification of prescriptions, therefore, representation is under the influence of the evolution of social practices" (Neculau A., Curelaru M., 2003). The fact that a social representation is formed does not mean that its structure is definitive. As the social representation is the result of social processes, its structure is constantly evolving, it is sensitive to social modifications. The scheme proposed by Guimelli regarding changes in social representations when new practices or ideas contradict old ones entails six stages: the occurrence of the event of great impact on the group, the modification of external circumstances due to the event, the elaboration of new practices within the group and the gradual increase in their frequency, the activation of schemes prescribing the new practices, the reorganization of the representational field, the formation of a new concept and its acceptance in the central nucleus of representation (Guimelli C., 1994).

2. Material and Methods

The present study is based on a qualitative methodology which has been implemented in two Roma communities in Romania and has consisted of submitting a survey to a number of 25 subjects. The research was performed in the period March – May 2014, within two Roma communities from South-Eastern Romania. All subjects were informed about the purpose and methodology of research and voluntarily consented to participate in the research. Moreover, all subjects were assured anonymity.

The method used in the qualitative research was the semi-structured interview, based on an interview guide which sought the investigation of the following dimensions: the significance of disease, causes of diseases, methods of treatment, superstitions connected to disease and types of diseases known from one's own experience or from the experience of other community members.

The interviews lasted 20-40 minutes and were carried out in Roma people's houses. We were joined and introduced by an educator from the community school. Interview codification was performed by retaining the subject's first and last name initials, age and gender.

Interview transcriptions were followed by a qualitative analysis performed by means of a trial version of the NVivo10 software.

The limits of research: the results of this research are limited to the analysed study group and cannot be generalized to the entire Roma population, given the qualitative design, which sought mainly to gather in-depth information, substantiated by the participants.

3. Results

The social representation of disease was analysed in terms of several dimensions, mentioned above and shown below.

3.1. *The significance of disease*

The first of these was the significance Roma people associate with disease. The most frequent associations they make with disease are: suffering, pain, stress, punishment from God, shame, death, isolation. Of these, suffering is the most frequent association, followed by stress: 60% of respondents nominated suffering among the significances of disease and just as many associated stress with the term "disease". Moreover, we note the creation of a vicious circle, where disease generates stress, and stress aggravates the disease or becomes the origin of new pathologies. *"Suffering, depression, hopelessness, isolation, upset, neglect by the family, family breakdown, loss of self-confidence, this is what I understand by disease"* or *"a state of stress, since it cannot be anything but stressful, in that you think. You submit to your thoughts more often. And it creates a state of stress and it leads to more diseases."*

Approximately 16% of respondents consider disease shameful, an aspect also identified by other studies (Pons, 1999; Petcut et al, 2013). Shame is caused especially by the external signs of disease, and to a lesser extent or not at all by diseases which do not produce visible changes. *"When you suffer from a disease which is visible or you have something a man can see, then you are ashamed to walk. When it's on the inside or internal, you're not. It's not noticed, no one knows what you suffer from. But when it's visible, you're really ashamed to show yourself".*

In addition, from the interviews conducted, the idea emerges that disease is a punishment from God, an otherwise very strong faith also revealed in the dimensions connected to the causes of disease, subsequently analysed. This association was also underlined by other studies in the field (Cook et al, 2012; McKee, 1997). *I understand this by the word disease; the disease is a sort of ordeal. How can I put this, it's a punishment from God.*

The Roma people included in the research bring up and associate disease with children. One of the possible explanations may be that, for this ethnicity, children's health status is one of the most precarious; incidentally, it has very high rates of infant mortality, compared with the mean of the majority population (Wamsiedel, Vincze, Ionescu, 2011; Becares, 2015; Condon & Salmon, 2014; Masseria, 2010; Carrasco-Garrido, 2011, Fésüs, 2012, Ruginis, 2010).

Table 1. The words' frequency associated with disease

Words associated with disease	Frequency in responses
suffering	60%
stress	60%
shame	16%
punishment	8%
children	20%

Thus, following the results obtained, we may assess that, for the Roma ethnic group, disease mostly signifies suffering associated with a high level of stress. We noticed the use of the term "stress", a relatively new concept, perceived rather as belonging to medical language, an argument in favour of our hypothesis regarding the changes occurring in Roma people's social representation of disease in recent years. However, shame and punishment are not absent as chief associations of disease – these two significations are part of the central nucleus of the representation of disease among Roma according to previous studies, and they are still retained.

A study carried out in Spain revealed that many Roma people "perceive health as the absence of disease, and disease as a disabling phenomenon, associated with death" (Carrasco-Garrido, 2011, Fésüs, 2012). Disease only exists to the extent to which it exhibits clear symptoms endangering the ordinary course of activities or the individual's physical existence. As soon as these symptoms disappear, the person considers himself healthy. The definition given by the *World Health Organization (WHO)*, based on the Western canon, explicitly mentions the difference in approach. For the international organization, health is "a general state of physical, mental and social wellbeing, not the mere absence of disease or infirmity".

3.2. *Types of diseases*

Regarding the types of diseases familiar to Roma people, the highest frequency belongs to somatic diseases and a very low frequency to psychic ones. Most references were made to diabetes, hepatitis, renal and cardiovascular diseases. The representation of psychic diseases is very vague. Most understand by psychic disease "a disease located in the head region", a reason why meningitis is most often considered "a psychic disease", followed by headache, sinusitis or cancer. Among psychic disorders, however, depression, epilepsy, debility or dementia are mentioned.

Table 2. Types of disease

Type of disease	Times mentioned
Diabetes	10
Cardiovascular diseases	7
Renal diseases	13
Hepatitis	11
Depression	4
Epilepsy	3
Dementia	6

The much higher frequency of somatic diseases occurring in members of the community probably explains, to a great extent, why this type of diseases is more familiar than psychic ones. As for psychic disorders, the one mentioned most often is depression, incidentally the malady of the century in the psychiatric register, if we go by *WHO* statistics. Therefore, the frequency of the disease also guides the frequency of mentions regarding types of diseases.

3.3. *Causes of diseases*

Another dimension we have analysed is that of the causes attributed by Roma people to disease. The belief that God is the source of diseases becomes evident here, a belief resulting from the perception of disease as a punishment applied by Divinity for past sins. The word "God" is mentioned no fewer than 47 times in answers regarding causes of disease in the 25 interviews. *Everything is from God. What He gives… that's all. They say it was a cold and it wasn't detected, but, anyway, you know, when you are born you have Three Fates by the window. And you live according to your fate. This is from God, of course. Well, if you knew, would you still drink or eat or smoke? Disease comes from God.*

God also appears as an instrument of the curse or the evil eye, also seen as sources of diseases and suffering. *"Well, my dad cursed me for being bad. I was going to steal. I was stealing, I wasn't going home, and dad cursed me, dad was beating me, I was swearing back at him, beating him back. God created this punishment. He said: 'God, make my son lame', and He made me lame. If he hadn't asked this thing from God, maybe God wouldn't have made me lame."*

These results are consistent with those communicated in scholarly literature, which suggests the interpretation of disease in the Roma community in mystical terms, as a punishment from God or as a curse. Moreover, disease is frequently associated with the feeling of shame, being a representation of spiritual and moral impurity (Dumitraş et al. 2013).

Though magical thinking is predominant in awarding causes to diseases they face, Roma people also have explanations fitting within a rather medical framework. What we found surprising here, however, was the almost unanimous opinion of cold – 31 mentions in the 25 interviews – as the source of all physical diseases faced. From a medical perspective, the following causes frequently identified were upset and stress, with 13 and 12 mentions, respectively. Nevertheless, there were Roma people who listed as causes of diseases an unhealthy lifestyle, genetic causes or poor hygiene.

Table 3. The causes of diseases

Causes of diseases	Times mentioned
God	47
Curse	8
The evil eye	3
Cold	31
Upset	25
Stress	27
Lifestyle	18
Genetic causes	6
Poor hygiene	7

Analysing answers referring to the causes of diseases, we find that, in this respect, changes in social representation take place more slowly, God still being perceived as the main cause of getting a disease, together with curses and the evil eye, these representing a durable nucleus of what we call "magical thinking", so characteristic of the ethnic group, according to studies of the past decades (Beaudoin, 2015; Taylor, 2014). Still, we cannot ignore that explanations like genetics, lifestyle, stress, poor hygiene make their way, though to a smaller extent, to the social representation of disease.

3.4. *Healing methods*

In terms of healing methods Roma people turn to when confronting a disease, the results of our analysis point out a paradoxical aspect. If "magical thinking" is predominant in the image of causes of disease, the most widespread healing methods are prevalently part of the medical register. Treatments, medication, surgery – these are the main healing methods mentioned 31, 14 and 26 times, respectively. The fact that the social representation of disease is in a permanent dynamic is also proved by the identification, during our interviews, of a relatively new concept in the theory on health and disease – *positive thinking*.

"You see there are many people who, by thinking positively, get healed of some diseases. If one thinks negatively, one gets sicker."

We also notice the acceptance of the placebo effect, based on trusting the doctor and the benefits of medication prescribed by him.

"I know, I've heard of a case where in a hospital there were some patients suffering from… I don't know what disease, cancer, something incurable, and the doctor knew well that these patients would not be cured and lately had been giving them sugared water. And the patients lived for another 6 months only with the thought that the drug was good. So they thought well. They thought positively."

Nonetheless, old cures still represent a variant of healing. But, in most cases, incantations, potions or teas are resorted to after medical treatments have not yielded the expected results or when Roma people consider they cannot follow the latter. Using coal according to certain rituals – mentioned 17 times – and the evil eye incantation – mentioned 16 times – are among the most frequent cures listed.

This is what I know, dear, why would I lie. And against the evil eye, when it hurts, you cast a spell. Even an infant this small, in diapers, takes it. I had my boy once, and Dorina cast a spell three times and spit on him and that was all, he was cured, he would've died in his infancy. But his niece died of the evil eye. She was too *beautiful. A man came to ask my brother to settle a wedding and he said 'begad, what a beautiful girl you have' and then my brother-in-law found her dead in her cradle. Healthy, she had nothing wrong. I have my oldest son, the prettiest child when we dress him up, and I took him in my arms and was walking down the road like that. And when I came back home, the boy was about to die, all of a sudden. He didn't have a fever, nothing… and then he gets the fever he gets it there… darn it. And that's it, he got that disease. We went to '9 Wormwoods'. He found an elderly man, I didn't know 'cause I was younger, that coal, I mixed it in a spoon, gave it to him to drink. The cure was ready; I took him to the hospital, but for no reason. We know from the elders a saying against the evil eye. I mean, when you get too much of a headache and it doesn't go away, not even with pills, not even like that, you say those words. And in most cases it pays off. I think there are a lot of Roma and Romanians who know it. There's a few words that must be said and it works against the evil eye."*

Table 4. Healing methods

Healing methods	Times mentioned
Treatment	31
Medication	14
Surgery	26
Coal	17
Incantation	16

Roma people frequently associate the occurrence of diseases with bad luck, a curse or the involvement of evil spirits. Hence, according to scholarly literature, the healing methods part of a supernatural register, rather than of one based on scientific information (Singh D., 2011).

The conducted interviews also show that traditional healing methods are considered somewhat of a taboo topic. Probably, in part, because Roma people know that the methods used by them are sometimes regarded ironically, other times merely with scepticism and most times blamed by the majority population, they are reluctant to talk about them. However, from the answers received, one distinguishes a pattern specific to the use of these methods: they come as a second option after the medical one, which has priority.

3.5. *Superstitions connected to disease*

One last dimension in the representation of disease analysed was that of superstitions connected to disease. This is where one encounters part of the beliefs identified as sources of diseases or as cures, dreams, but also some superstitions also common among the majority Romanian population.

Table 5. Words associated with superstitions about disease

Words associated with superstitions about disease	Times mentioned
Cursed	12
God	8
The evil eye	9

"The evil eye. The only, sole superstition is the evil eye."

"I dreamed a dream one night. It appeared I had a house in that dream, but not this house of mine that I know. It was a house and I was telling them 'the house isn't mine, it's not like this in my house', I said. Dude, and I made that house. For us, for us gypsies, or that's what I think, I mean my family. When you dream something, it happens. And they say that these dreams of houses, so when you build a house, would be some hardship and there will be upset, and, not to exaggerate, in 2 weeks at most a 13-year-old cousin of mine died with that big accident of ours here."

"I had this older one of a year and 10 months and that lady told my fortune in coffee grounds, she says: 'take care with the girl, for she will get hurt, for she will shed blood', that's what they say, you know? 'You will take her to statesmen, to white doctors, with white coats, like that, but fear not, it'll be fine". Let's say in a week or two, three at most, the girl got hit in the eye and was torn from here to here like so, halfway. Exactly so, she shed blood, I took her to doctors, I had her stitched and I told myself I'd never get my fortune told again. It was exactly as she told me from the coffee grounds."

4. Conclusions

The social representation of disease among the Roma ethnic group went through changes compared to the representation outlined by research conducted a few years ago. Although many elements of the central nucleus of representation are maintained, such as disease regarded as a divine punishment, superstitions, traditional healing methods, marks of magical thinking, we cannot ignore the penetration of new elements in everyday language: causes of diseases from the medical register, diagnoses or medical treatments. Additionally, an important aspect is the way in which the doctor-patient relationship has evolved to its present state of almost total freedom from the constraints imposed by traditional beliefs. One must note, however, that disease and, implicitly, death remain taboo topics in discussions with Roma people, just as references to traditional practices and beliefs are made reluctantly.

Taking into account the results obtained in the present paper, we may state that all favourable prerequisites – accurate perceptions of the facts, continually changing social representation - exist for the continuation of an education regarding health status and prevention among the Roma ethnic group.

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ETHICAL ASPECTS OF USING BIOSPECIMENS IN RESEARCH

ANTOANELA NAAJI[1]

REZUMAT. Aspecte etice privind folosirea probelor biologice în cercetare. Lucrarea prezintă câteva considerații privind aspectele bioetice în utilizarea și depozitarea probelor biologice. Una dintre cele mai importante preocupări este modul în care consimțământul informat general este adaptat la această problemă specifică, ținând seama de principiile etice. Un alt aspect este legat de provocările ridicate de obținerea unui consimțământ informat valid. Pentru o mai bună abordare a acestor probleme specifice, pe baza experienței din SUA în acest domeniu, este prezentată, din punct de vedere juridic, situația din România cu privire la utilizarea probelor biologice, în scopul de a determina unde ne aflăm și ce este necesar de făcut pentru a îndeplini standardele bioetice internaționale.

Cuvinte-cheie: *probe biologice, etică în cercetare, bioetică, aspect legale, consimțământ informat*

ABSTRACT. The paper presents some considerations regarding bioethical aspects in using and storing biospecimens. One of the most important concerns is the way the general informed consent is adapted to this specific problem, taking into account ethical principles. Another aspect is related to the challenges raised in obtaining a valid informed consent. For a better approach to these specific issues, building on the experience of USA in this field, the situation in Romania concerning the use of biospecimens is presented from a legal point of view, in order to determine where we are and what is needed to meet the international bioethical standards.

Keywords: *biospecimens, ethics in research, bioethics, legal aspects, informed consent*

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[1] *Assoc. Professor, "Vasile Goldis" Western University of Arad, Bd. Revolutiei nr. 94-96, 310025 Arad, Romania. Email: anaaji@uvvg.ro*

Introduction

The collection, storage and usage of biospecimens for research, especially in future studies, raise a lot of controversies and introduce complex legal and ethical issues. Each investigator should consider carefully how to safeguard the rights of study participants, as well as ensure the privacy and confidentiality of personal data.

Key ethical issues include respect for autonomy of research participants, protecting research subjects from breaches of privacy and confidentiality, developing appropriate policies for biospecimen use, and ensuring that biospecimens are used in scientifically sound research. Legal issues include the need for biospecimen resources to adhere to relevant regulations related to the collection, storage, dissemination, and use of biospecimens [7].

According to the National Cancer Institute, "biospecimens are materials taken from the human body, such as tissue, blood, plasma, and urine that can be used for cancer diagnosis and analysis. When patients have a biopsy, surgery, or other procedure, often a small amount of the specimen removed can be stored and used for later research. Once these samples have been properly processed and stored they are known as human biospecimens" [8]. Even if the definition refers for biospecimens collected for research concerning cancer disease, it can be extrapolated to other types of clinical studies.

For example a single biopsy could provide several biospecimens, including multiple paraffin blocks or frozen biospecimens. A biospecimen can comprise subcellular structures, cells, tissue (e.g., bone, muscle, tissue, and skin), organs (e.g. liver, bladder, heart, and kidney), blood, gametes (sperm and ova), embryos, foetal tissue, and waste (urine, feces, sweat, hair and nail clippings, shed epithelial cells, and placenta). Parts of a biospecimen are referred to as samples. Each sample may contain DNA, proteins, and other molecules important for understanding disease evolution [7]. The biospecimens are usually recorded with information about the patient from whom the biospecimen was taken, including data about their medical conditions and history. The biospecimens are stored in biorepositories (or biobanks). They are "libraries" where biospecimens are stored and made available for scientists, for therapeutic or research purposes. There are thousands of biorepositories in the United States, which vary widely by size, the type of biospecimens collected, and the categories of studies for which they are intended [8].

The next sections of the paper will address the following aspects: the ethical implications of informed consent in the process of collecting, storing and using biospecimens and how it must be adapted to these purposes, presentation of the most important ethical and legal issues in this matter in the USA, and a short presentation of regulations in Romania. In the conclusions, a few considerations regarding the challenges for biospecimens-based research are mentioned, in order to improve Romanian legislation in the field.

Aspects Regarding Informed Consent for the Collection, Storage and Usage of Biospecimens

Informed consent is considered to be a cornerstone of the ethical conduct of research involving humans. Based on the ethical principle of respect for persons (the concept that all people deserve the right to fully exercise their autonomy), the goal of informed consent is to ensure that subjects are aware of the risks and potential benefits and make a voluntary decision about participating in the research [9]. The philosophical justification of informed consent is that in research where humans are involved, respect for the autonomy implies that the patient has the capacity to act intentionally, with understanding, and without controlling influences that would lower against a free and voluntary act. As D.W. Brock mentions, “the rule that with a few exceptions, research with humans should not take place without participants’ informed consent is a settled ethical and legal principle” [3].

Throughout the history of bioethics, the necessity of informed consent appears in different documents through some simple statements such as: “The voluntary consent of the human subject is absolutely essential” [1]; “Respect for persons requires that subjects, to the degree that they are capable, be given the opportunity to choose what shall or shall not happen to them” [2]; “After ensuring that the potential subject has understood the information, the physician or another appropriately qualified individual must then seek the potential subject's freely-given informed consent”[10]; “Except as provided elsewhere in this policy, no investigator may involve a human being as a subject in research covered by this policy unless the investigator has obtained the legally effective informed consent of the subject or the subject's legally authorized representative” [11].

Thus, the main characteristic of a valid inform consent is that a participant in a study must have the capacity to make an autonomous decision regarding three aspects: to have and to understand the information needed so that the act of accepting to participate in the study/research be well-documented (informed), the information must be given by a competent person and the decision has to be a voluntary one. In a simple representation, a valid informed consent is based on information, the competence of the person who gives the information and voluntariness (Fig.1).

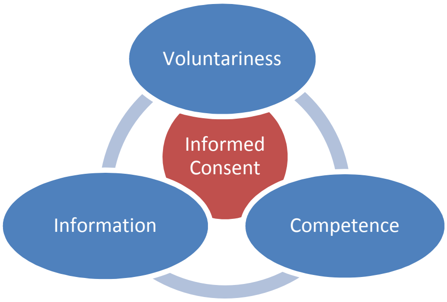

Fig. 1. A valid informed consent

In order for the subject to be informed, it is important to give him/her a detailed description of the research, adapted to his/her level of understanding, to present the effects, including the risks involved, and to give the possibility to ask any question related to that trial, so that the information to answer such questions as 'What?', 'Why?', 'How?', 'By whom?' would be provided; what will happen to the participant, the possible risks and discomforts, as well as the benefits, are issues which must also be addressed. The study subject should understand that participation is completely voluntary and he/she can withdraw at any time without loss of any benefits.

When we are talking about what consent means, we have to take into account that the participant has the capacity to decide and that the consent is voluntary and non-coerced.

Considering the content of the informed consent, there is some general required information, but in some cases there is a need for specific information, such as in research involving children, people with disabilities or mental diseases. Also specific informed consent is necessary for genetic and genomic research requiring access to human DNA from biological specimens, which can be used in multiple research studies. Some templates of informed consent, adapted to specificities of these types of studies, are available on the WHO web page [12].

Regarding the informed consent for researches dealing with the collection, acquisition, storage, use, and disbursement of biospecimens, the document should describe the planned and potential future uses of the collected biological specimens. In addition to the general data, such as the description of research in terms of stages and activities, the possible risks as well as the benefits, the extent of confidentiality, the existing medical treatments in case of injuries or disabilities, etc., the informed consent should also contain some specific data. The difficulty of introducing this specific information is due to reasons such as impossibility to describe in detail the future research for which the biospecimen might be used at the time when it is collected; uselessness of samples after donors' death in absence of generalized consent for future use; privacy/confidentiality risks if samples are not anonymized, but these can be minimized by appropriate coding precautions. Also if samples are anonymized, they are potentially less useful for research [4]. There are other aspects regarding future researches connected with cultural issues which are relevant to informed consent in terms of the collection, storage and use of biospecimens, but these will not be approached in this paper [6].

Considering all these aspects, from a theoretical point of view, the investigators conducting the researches where biospecimens are used have some options related to the way informed consent is obtained for covering the ethical aspects. Some of them are:

- researchers should re-contact participants to obtain specific consent for each additional use, but in this case difficulties might appear in terms of what it means to contact the participants, or they might even change their minds, preventing the subsequent use of biospecimens;
- the informed consent should contain a statement that stored materials will be used in future research, some details regarding the diseases that may be studied, and at least some goals of the research project;
- participants could provide general (blanket) consent for all future uses of their biospecimens at the time when they are collected.

In most of the cases, the last option is considered more appropriate [5].

Legal Aspects Related to the Collection, Acquisition, Storage and Use in Research of Biospecimens

In this section I will present a few legislative documents regarding the regulation of these activities, with reference to US and Romanian legislation.

As far as US regulations are concerned, the issues regarding the collection of biospecimens during the course of medical care, the timing of consent, the storage, and the future use of biospecimens for research are very well documented. Most of these aspects are regulated, with rules which include ethical guidelines and logistical constraints.

The NCI Best Practices for Biospecimen Resources Office of Biorepositories and Biospecimen Research, developed by the National Cancer Institute, National Institutes of Health and the U.S. Department of Health and Human Services in 2011 contain a chapter regarding biospecimen collection, processing, storage, retrieval, and dissemination. There is additional information regarding data management, inventory control and tracking. The general best practices mentioned in this document apply to all types of biospecimens, such as wet tissue, frozen tissue, paraffin-embedded tissue, glass slides, blood, serum, urine, etc. [7].

In Romania, ethical aspects regarding the obtainment of informed consent are comprised in the Guide on good practices in clinical studies, but this refers more to the organization and conduct of clinical studies regarding the use of pharmaceutical drugs on human subjects. This guide (approved by Res. No. 39/27.10.2006), in chapter V – The investigator, subchapter V.8. – Informed consent expressed by study subjects, in addition to rules regarding the obtainment of informed consent, provides at Art. 64:

(1) "In order to obtain and record informed consent, the investigator must comply with legal regulations in force, good practices in clinical studies and ethical principles originating in the Declaration of Helsinki regarding human rights.

(2) Before initiating the study, the investigator must obtain the written approval/favourable opinion of the EC regarding the informed consent form and any other information conveyed to subjects" [13].

Likewise, Art. 65. Para. (2) provides that: "Any revision of the informed consent form and written information must obtain the written approval/favourable opinion of the EC before being used" [13].

In Romania, legislation regarding the collection, storage and use of biospecimens in research is still inadequate. There are, however, a few laws and resolutions partly regulating these activities from an ethical point of view. Here we might mention:

- Law no. 282/2005, republished and featured in the Official Gazette no. 188 of 17 March 2014, on the organization of blood transfusions, human blood and blood component donation, as well as quality assurance and safety in healthcare, for therapeutic use, but which does not refer to the use of blood samples in research, only to the blood donation process, and the way in which privacy and data protection are ensured so that the donor could not be identified, while only considering the therapeutic component [14].

- Law no. 95 of 14 April 2006 on healthcare reform, republished in the Official Gazette no. 652 of 28 August 2015, Title VI – Harvesting and transplanting organs, tissues and cells of human origin for therapeutic purposes, which establishes, in Chapter II, the rules regarding donation and organ donors, tissues and cells of human origin, but only for transplantation purposes. For example, Art. 144 stipulates the methods and conditions in which organs, tissues and cells of human origin are harvested from living donors, such as:

- at paragraph a): "organs, tissues and cells of human origin can be harvested, for therapeutic purposes, from living adult persons, with full capacity of exercise, after having obtained their prior, free, express and written informed consent, according to the form template approved by order of the minister of health. It is prohibited to harvest organs, tissues and cells from undiscerning persons" [15].

- at paragraph c): "the donor can withdraw their consent until the moment of harvesting" [15].

Article 146 provides, at Para. (6), regulations regarding how donation should be approved by the committee established to this end, as well as the fact that: “Harvesting blood, skin, sperm, femur head, placenta, umbilical cord blood, and amniotic membranes from living donors, for therapeutic purposes, is done in compliance with bioethical rules comprised in the regulation of the committee approving donation from living donors, without requiring the approval of this committee” [15].

Consequently, none of the legislative regulations makes direct reference to how biospecimens are collected, stored and used in research, as defined in the law, but only to how they are harvested, stored and used for therapeutic purposes (e.g. for blood transfusions, for transplants). Nevertheless, Romania, as an EU member, must comply with all European directives related to the topic approached in this paper.

Conclusions

The way biospecimens are used in research, especially in future studies, is an issue which entails numerous ethical and legal problems. There are still questions that are quite difficult to answer and which often pose difficulties for ethics committees or IRBs. Such questions are: How to obtain an autonomous decision about future use of biological samples?; Is the informed consent really informed?; How to evaluate the risks for future researches?; How to ensure confidentiality (security of computer files)?; Who owns or has the custody of biospecimens?; Who has access to biospecimens and data? Who has the intellectual property?

Of considerable importance is the way in which these aspects are regulated from a legislative point of view and the ethical norms imposed in each country. While in the USA legislation concerning ethical aspects related to the collection, storage and use of biospecimens in research is covered, even if the patients’ consent to future use of biospecimens is further complicated by the discrepancies between relevant federal regulations, in Romania, and even in some countries in Europe, several efforts are under way to address informed consent, privacy, ownership, and access issues with respect to biospecimen collection and use. Consequently, further discussions are needed among stakeholders within the biospecimen research community in order to make these processes as transparent as possible.

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[13] *** - Hotărârea nr. 39/27.10.2006 referitoare la aprobarea Ghidului privind buna practică în studiul clinic, Agenția Națională a Medicamentului/Resolution no. 39/ 27.10.2006 on the approval of the Guide on good practices in clinical studies, National Agency of Medicines, available at: http://www.anm.ro/anmdm/med_studii_legislatie.html

[14] *** - *Legea nr. 282/2005 privind organizarea activității de transfuzie sanguină, donarea de sânge și componente sanguine de origine umană, precum și asigurarea calității și securității sanitare, în vederea utilizării lor terapeutice, republicată în M. Of. nr. 188 din 17 martie 2014 / Law no. 282/2005 on the Organization of Blood Transfusions, Human Blood and Blood Component Donation, as well as Quality Assurance and Safety in Healthcare, for Therapeutic Use, Republished in the Official Monitor no. 188 of 17 March 2014,* available at: http://www.clr.ro/rep_htm/L282_2005_Rep1.htm

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RESEARCH MISCONDUCT IN MEDICAL SCIENCES

JELENA DOTLIC[1], VIDA JEREMIC[2]

REZUMAT. Conduita greșită în cercetarea medicală. Conduita necorespunzătoare în cercetare este un fenomen foarte răspândit, care, în medicină, poate afecta oamenii. Prevenția acesteia include educarea cercetătorilor, promovarea integrității autorilor și a eticii, scăderea presiunii academice, crearea și ascultarea de norme, dar, de asemenea, investigarea actelor de plagiat și a fraudei.

Cuvinte-cheie*: medicină, cercetare, conduită necorespunzătoare, incidență, prevenție*

ABSTRACT. Research misconduct is widespread phenomenon, which in medicine can potentially harm people. Its prevention includes educating researchers, promoting authors integrity and ethics, lowering academic pressure, creating and obeying norms, but also inspection for plagiarism or fraud.

Keywords*: medicine, research, misconduct, incidence, prevention*

Why is It Important to Talk about Research Misconduct in Medicine?

Scientific misconduct is a widespread phenomenon, belonging to the category of irresponsible research of inappropriately performed or published studies (12, 17). By producing unreliable results, wrong decisions are made, resources wasted, people harmed or killed and environment endangered. Thus, it is important to prevent and uncover scientific misconduct and to promote scientific honesty (5). Responsible research encourages general trust in science

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[1] *Corresponding author, MD, PhD, Clinic for Obstetrics and Gynecology, Clinical Center of Serbia, Faculty of Medicine, University of Belgrade, Visegradska 26, Belgrade, Serbia. Email: enadot@yubc.net*

[2] *Department of Humanities, Faculty of Medicine, University of Belgrade, Dr Subotica 8, Belgrade, Serbia*

and scientists (7). One of the most problematic fields regarding research misconduct seems to be medical science (2, 17). Contemporary medicine is „evidence-based", meaning that every decision in medicine should be supported by scientific proof. The explosion of medical writing can be partially explained by scientific progress and new technologies being applied in diagnostics and patient treatment. Still, when investigated more thoroughly, besides original papers, a significant number of publications in medical journals can be classified as some type of research misconduct (2, 19).

Definition of Scientific Misconduct

A research error can be made unintentionally or deliberately (1). Research misconduct does not include honest error, sloppy and disorganized behaviour, or a difference of opinion. Scientific community has set the criteria for research practice that should be considered as misconduct: a significant deviation from established practice of the research community, misconduct is preformed intentionally and the allegation of misconduct is proven by clear evidence (13).

Different definitions of research misconduct are being used according to various legislative regulations and circumstances (11, 19). The widest and the most commonly used classification, made by the American Office of Research Integrity, divides misconduct into: fabrication, falsification and plagiarism (13). However, it is clear that some other forms of malpractice can also cause significant damage (undisclosed conflict of interests, honorary or "ghost" authorship, reporting results without "outliers", publishing the same data in several journals) (12). Therefore, a wider definition of research misconduct also involves so-called questionable research practices (16). These are all procedures that are done contrary to ethically accepted values in designing and undertaking the study or publishing the obtained results, such as inaccuracy, misrepresentation and bias in research as well as problems with authorship (11).

Fabrication includes making up data or results and publishing them as if they were real (10). Usually it means that data were never collected or tested in the field, or reporting results of experiments that were never conducted. Fabrication is considered the most serious fraudulent behaviour, with the clear intent to deceive. Fabrication is strongly condemned by scientific community, which keeps it very rare (6).

Falsification is distortion of data or results. It includes "manipulating research material, equipment or processes, changing or omitting data or results, causing inaccurately represented research records" (10). Falsification can be done in several ways with different levels of scientist's intention. So called "data cooking" is selecting and reporting only data that fits the hypothesis; "trimming" data is smoothing of irregularities in order to make results look more accurate. Falsification can be performed through inappropriate methods of data analysing, the exclusion of outliers, or unpermitted manipulation of graphics (4).

In the field of medicine, both fabrication and falsification can have grave consequences. In these cases of misconduct the results are either made up and not tested at all, or presented incorrectly according to the desires of authors and disregarding the truth. This is not only unethical, but the conclusions and recommendations of such work can be harmful for people, which is of the utmost importance in medicine.

Plagiarism is a violation of copyright, meaning presenting someone else's ideas or findings as yours, without citing the original source and author (14). World Association of Medical Editors set the rule that copying six consecutive words with 30 identical characters should be considered as plagiarism (14). Still, it is not that easy to differentiate plagiarism from original work. Moreover, there are different variants of plagiarism and, although all unethical, some are worse than the others (14). Writing plagiarism (using numerous same words from the original so that almost all source is copied, changing some words but copying the sentence structure without citations or incorrect citations) is somewhat less problematic and therefore quite frequent. Conversely, presenting someone else's work or ideas as yours is the worst type of plagiarism and should be considered as theft (14).

Another special form of plagiarism is self-plagiarism or duplicate, redundant or secondary publications. These are republications of an article in which either the most important parts overlap or the majority of text is the same with the already published copy (1, 10). Types of self-plagiarism are: republishing an article with identical content and the same subjects in two different journals (the worst violation); republishing some parts of the main study as a separate manuscript; republishing an article with adding few more data, but using the same text of the original work (1, 10).

Unethical authorship is the most common publication misconduct (2, 16). The International Committee of Medical Journal Editors has recommended that the manuscript authors should be only those researchers who have significantly contributed to all stages of investigation from idea to publication of results (9, 12). All authors must know the study aim, methods and findings. Although large research teams are necessary to perform different components of the work, in medical journals even case reports have numerous authors (2). Gift authorship to friends or exchanging authorship between investigators in order to amplify their publications should be strictly banned (8, 12). Younger researchers should be protected from pressure of giving authorship to professors, mentors or older colleagues (2, 15). Still, the authors of this article believe that all hard work on the research, such as data collection, should qualify a researcher for authorship. There is an ongoing debate on this matter. The majority of editors believe that authorship is not linked with hours of work but with its intellectual quality (2). Nevertheless, responsibility for the accuracy of data-base, and results obtained from it, lies greatly on the data collector, which makes that person an essential part of the research team. Furthermore, the person who has collected the data (performed the experiments, interviewed the patients) definitely knows the study aim and method.

Why Does Scientific Misconduct Happen?

Misconduct is present in all human activities, so it is not odd to find it in medical science as well (3). Some of the reasons for scientific misconduct may be found in medical research environment, which is highly competitive and demanding. Stressful activities accompanying scientific career, like struggling to get funds and publish your work, put pressure on researcher to act irresponsibly (11).

The common etiological factors are the need to publish for career advancement or the hospital status, unhealthy ambitions, the will to grow rich and the lack of motivation to seek the truth. Having more publications brings greater recognition and better opportunities. Published authors are invited to present their results on conferences, enabling them to visit different places and sometimes bringing even profit in speaker's fees. Moreover, being a published author may boost ones self-esteem and vanity. Other authors emphasize lack of education and training on research ethics as very important factors (2, 5).

However, career promotion is the leading cause of misconduct and stress for investigators in Europe (19). For medical scientists, publishing research papers in journals with high impact factors has become a major criterion for career advancement. Number of publications and their citations are a measure of success (10). Some medical faculties consider having high impact papers obligatory prior to defence of doctoral thesis. Furthermore, many grants and project sponsors are requesting that researchers have regular publications in order to continue receiving funds. Non-publishing doctors are invisible to the scientific community (10).

The Process of Dealing with Scientific Misconduct

According to the Scientific Misconduct Strategy adopted in 2012, host institutions are responsible for detecting and addressing misconduct allegations (5). However, it seems that in practice the most important role have journal editors and reviewers. Editors should test every submitted paper for plagiarism using one of the many currently available software. Reviewers should search literature and check for duplication of results, idea theft, fabrication or falsification. Original paper requires addition of new findings to the previous data. However, obtaining new results is not easy and does not happen on regular bases. Any well-done research takes months to perform and publish, implying on the fact that not more than a couple of papers can be submitted to journals annually. Author with extremely large number of publications who produces a new paper on weakly/monthly bases should raise editors' suspicion.

In the United States and the European Union there are special scientific boards that are in charge of dealing with allegations of scientific misconduct (US: Office of Research Integrity; EU: European Research Council) (5). Almost all European countries have official national guidelines strictly defining how to address research misconduct, but they differ significantly among countries. Conversely, some countries (usually developing and undeveloped) still do not have policies regulating scientific misconduct, making it easier to commit (5).

The usual procedure starts when allegation of scientific misconduct is reported. First, the board examines if the allegation seems accurate. During the whole procedure authors should be notified and given the chance to explain their work. If there appears allegation truthful, an analysis of the whole performed study is undertaken (5). If misconduct is not confirmed the case is dismissed. But if it is proven, the board determines sanctions. The extent of action should match the severity of the fraud. Manuscript revision is demanded if it is the question of writing plagiarism or incorrect references (2). Authors can get the letter of reprimand and be sent to educative counselling. However, paper must be rejected if it cannot be corrected (forgery or theft of the idea or methodology) while authors can be punished by suspension or even employment termination (5).

Prevention of Misconduct

The education about research ethics, scientific methodology, literature review, proper paper writing and types of research misconduct and how to avoid it, should be provided even to medical graduate students and definitely postgraduate students who are starting their career as investigators (20).

Education could be in the form of formal classes, but also in the form of discussions, workshops, etc. Important factor for reducing unethical research behaviour is mentoring (18). Mentor as a role model for students, has a great responsibility to teach ethical standards through his own proper actions and to correct potential misconduct at the beginning stages. Institutions involved in research work should promote scientific integrity with policies and educational programs (18).

In order to avoid plagiarism of literature data used for references, authors should paraphrase (express someone else's ideas in your own language) and summarize (take out the essence of someone else's work) the information from other papers (10). Authors should acknowledge the original source and check that references are correct and used appropriately in the text. Written permission should be obtained to use other investigators published work.

However, sometimes there are not too many ways to say some well-known definitions. Moreover, some reviewers insist that every sentence in discussion is based on some already published paper. If an author is giving his own opinion or explanation of observed phenomena and obtained results paper will most likely be sent to corrections or even rejected. This is completely contrary to the concept of originality. So, before submission authors are advised to run their manuscript through plagiarism-check websites (10).

Moreover, current polices in scientific community must be changed. The pressure to publish must be taken of the researchers. This can be done by making new and less demanding requirements for career promotion and emphasizing quality and not quantity of papers or impact factors. Expectations of a researcher in terms of publications that are needed for sustaining project or scholarship funding should also be limited to a conceivable publication rate. Demand for a new original idea tested on a large sample and published in a high impact journal every 3 to 4 months is unrealistic and it is clearly pushing investigators to misconduct (at least self-plagiarism and even complete fabrication). Harvard University tried to implement the rule that just 10 articles are required when applying for the post of a full professor (2). This rule can be used universally.

Conclusion

It is clear that more discussions about research misconduct are needed to promote good scientific practice and raise the awareness of the issue. By taking serious and conscientious approach to research ethics scientific community, through discussions, education and intensive work, can make codes and polices that would support research integrity, lower academic pressures and prevent misconduct in medical science.

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SLOVAKIA FORCED STERILIZATION ON RROMA WOMEN PRACTICES. AN ETHICAL CASE ANALYZE

MARIA ALUAȘ[1]

REZUMAT. Practici de sterilizare forțată a femeilor de etnie romă în Slovacia. O analiză etică. Acest articol prezintă câteva considerații etice referitoare la practica de sterilizare forțată a femeilor de etnie romă în unele țări din Europa de Est (cazul Slovaciei). Aceste practici sunt efectuate de zeci de ani în anumite țări, Slovacia fiind primul caz judecat la Curtea Europeană a Drepturilor Omului de la Strasbourg, Franța. Gândindu-ne la aceste fapte ne dăm seama că ne confruntăm cu riscuri imense pentru pacienți și nu numai pentru cei de etnie romă, ci pentru noi toți. Pacienții merg la medici în considerentul profesiei lor, pentru că sunt bolnavi și au nevoie de ajutor. Ei nu merg la medici, din cauza opiniei personale a acestora cu privire la ceva, iar dacă medicii nu acționează pentru binele pacienților, aceștia își vor pierde încrederea și le va fi frică să meargă la spital. Astăzi vorbim despre persoane de etnie romă, dar cine știe ce fel de criterii de discriminare vor fi mâine, sau în câțiva ani? Avem nevoie de medici care să-și exercite profesia, în mod corespunzător, și care să cunoască foarte bine natura profesiei lor și a limitelor acesteia. Acesta este mesajul de reținut din acest caz.

Cuvinte cheie: *practici de sterilizare forțată, femei de etnie romă, principii bioetice, aspecte legale, consimțământ informat.*

ABSTRACT. The paper presents some ethical considerations regarding forced sterilization practice on Roma women in some countries in Eastern Europe, a case from Slovakia. These practices are done by decades in same countries and Slovakia was the first case jugged by the European Court of Human Rights in Strasbourg, France. Thinking to the facts we realize that we are facing with huge risks for patients and not only for Roma people, but for all us. Patients go to the doctors because of his or her profession, and because they are sick and they need help. They do not go to doctors because of his or her personal opinion on something, and if doctors do not act for patients good, patients will lose trust and confidence and they will be afraid to go to the hospital. Today we talk about Roma

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[1] *Assist. Professor, PhD, UMF Iuliu Hațieganu, Center for Bioethics, UBB, Cluj-Napoca, Romania, maria.aluas@umfcluj.ro*

people, but who knows what kind of discrimination criteria will be tomorrow, or in few years? We need doctors who do their job in a properly way and who knows very well the nature of their profession and its limits. This is the take-away message from this case.

***Keywords**: forced sterilization practices, Roma women, bioethics principles, legal aspects, informed consent*

Introduction

Few years ago, media presented a huge scandal from Slovakia. It was about the cases of forced sterilization on Roma women, without inform them and without any consent. It was actually about the intention of someone to regulate births on Roma people. News about this situation shocked the public opinion and in the same time raised some questions: what do medical doctors in their day-by-day practice, why they did such a procedure, and who decided it? Are medical doctors free to do correctly their job, or they must to execute some practices decided by others? This paper will present facts, ethical consequences, and legal regulations on human rights related to the elimination of all forms of discrimination against women and to their rights to informed consent.

Facts

On August 2000 a woman from Slovakia, VC, 20 years old, was sterilized at the Hospital and Health Care Centre in Prešov (Eastern Slovakia), center set under the management of the Ministry of Health, during the delivery of her second child via Caesarean section. The procedure entailed tubal ligation, which consists of severing and sealing the Fallopian tubes in order to prevent fertilization. While they were in the height of labor, hospital staff insisted that she sign a consent form for sterilization, without informing her about what the procedure entailed. She was only told that a future pregnancy could kill her and was pressured to immediately undergo the procedure. VC did not understand what she was agreeing to but, she signed the form. After learning that the sterilization was not medically necessary, VC filed a civil lawsuit in Slovakia. The pursuit of justice at home failed, and in 2007 she filed a complaint against Slovakia at the European Court of Human Rights. On November 2011, judges ordered Slovakia to pay € 43,000 in damages, costs and expenses. They ruled that forced sterilization is a violation of the European Convention on Human Rights (specifically art. 3, which prohibits torture or inhuman and degrading treatment, and art. 8, which protects the right to private and family life). In its decision, the Court noted that sterilization is never a lifesaving procedure and cannot be performed without the full and informed consent of the patient even if doctors believe that future pregnancy may pose a risk to the woman[2].

Tubal ligation, a surgical technique first proposed in early 19th century England, has been promoted as a permanent birth control method ever since[3]. While voluntary sterilization is an important contraceptive option, tubal ligation has also been forcibly performed upon women in marginalized populations worldwide, motivated all too often by frankly eugenic considerations[4]. Sterilizations performed against the will or without the knowledge of the patient go by many names: forced sterilization (when a patient is never consulted or informed about the sterilization); coercive sterilization (when patients are threatened or offered incentives to undergo sterilization); and involuntary sterilization, which is sometimes used to speak about both forced and coerced sterilization[5].

Forced Sterilization on Rroma Women in Central Europe

The experience of Rroma women in Europe is a case in point. With a conservatively estimated population of 10 million people[6], the Rroma are Europe's largest ethnic minority. Their forebears are posited to have come to Europe from India more than a millennium ago, when they were defeated in

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[2] *Sterilized Roma woman wins human rights appeal*, available at http://www.humanrightseurope.org/2011/11/sterilised-roma-woman-wins-human-rights-appeal/, last accessed on the 12.12.2015

[3] See Medscape Reference, *Tubal Sterilization*, by Robert K Zurawin, MD (22 April 2011), available at http://emedicine.medscape.com/article/266799-overview#a0101, last accessed on the 12.12.2015

[4] Matthew Connelly, *Fatal Misconception*, Cambridge, MA/London, England: Belknap Press of Harvard University, 2008

[5] Men have also been targeted for vasectomy in some Asian countries, notably India, where incentive programs promoting tubal ligations and vasectomies still continue; see The Times of India, "Get sterilized in Rajasthan, drive home a Nano", Ali, Syed Intishab, Syed Intishab Ali June 30, 2011, http://timeso!ndia.indiatimes.com/india/Get-sterilized-in-Rajasthan-drive-home-a-Nano/articleshow/9045645.cms. For more on the global nature of this abuse, see www.stoptortureinhealthcare.org

[6] According to the Council of Europe, Roma and Travelers Division, the average estimate of the Romani population in Europe (i.e., the 47 member states of the Council of Europe area, which includes most of the CIS countries, Russia and Turkey), is 11,256,900, with a maximum estimate of 16,118,700 (August 2009 update). The World Bank provides a map with Romani populations listed as a percentage of country populations based on data from 2007, but this does not include any of the CIS countries; see http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/ECAEXT/EXTROMA/0,,contentMDK:20339787~menuPK:904252~pagePK:64168445~piPK:64168309~theSitePK:615987,00.html

warfare against the Ghaznavid rulers of Persia around 1000 CE. After being brought to Armenia and Anatolia as soldiers and servants, they migrated further west and were enslaved between the 14th and 19th centuries in some countries in Europe.

The 20th century saw them racially targeted by Nazi Germany for annihilation, and many perished during the Holocaust. In the postwar period, most Romani people in Europe lived under communist rule throughout the Soviet bloc. Since 1989, when most countries in that region began a transition to democratic governance and market economies, members of the Romani minority have experienced a profound degradation in life expectancy, social status, and standard of living[7]. They have also been the targets of deadly pogroms committed by neo-fascist and neo-Nazi groups, and forced evictions involving police brutality throughout Europe[8].

Thousands of Roma women were sterilized without their consent in Central and Eastern Europe during and after communism[9]. The extent of these *practices in Slovakia is exposed in detail in the 2003 Report, Body and Soul: Forced Sterilization and Other Assaults on Roma Reproductive Freedom in Slovakia*[10]. Countries known for these practices are: Czech Republic, Slovakia, and Hungary.

Classification of These Practices

What has been done? What were reasons for these practices? Did they a kind of research or they only put in act some decisions of others? What was the goal of physicians?

Research Ethics

Research Ethics is defined to be the ethics of the planning, conduct, and reporting of research. Research ethics should include protections of human and animal subjects who are involved in these practices. Medical research has

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[7] World Bank, *Roma in an Expanding Europe*, 2005, available at http://siteresources.worldbank.org/EXTROMA/Resources/roma_in_expanding_europe.pdf

[8] C. Cahn and E. Guild, *Recent Migration of Roma in Europe*, Council of Europe and OSCE, 2008, available at http://www.osce.org/hcnm/78034, last accessed on the 12.12.2015.

[9] According to the ombudsman's estimate, from the 1980s until today, as many as 90,000 women may have been sterilized throughout the territory of the former Czechoslovakia." (Author's translation.) Lidovky.cz, "Ministr Kocáb: Politování sterilizovaných žen je první fáze" (24 November 2009), http://www.lidovky.cz/ ministr-kocab-politovani-sterilizovanych-zen-je-prvni-faze-pld-/ln_domov.asp?c=A091124_184921_ln_domov_tai

[10] *Body and Soul: Forced Sterilization and Other Assaults on Roma Reproductive Freedom,* Center for Reproductive Rights, available at http://www.reproductiverights.org/document/body-and-soul-forced-sterilization-and-other-assaults-on-roma-reproductive-freedom, last accessed on the 12.12.2015

two main arms: *preclinical* research and *clinical* research[11]. The first one tries to generate a better understanding of disease and new strategies for treatment. The second one evaluates new treatments for safety and efficacy. Clinical research often takes the form of a clinical trial, which is a carefully designed experiment to test the safety and effectiveness of a drug, device, or preventive measure in a group of human patients.

> The primary purpose of medical research involving human subjects is to understand the causes, development and effects of diseases and improve preventive, diagnostic and therapeutic interventions (methods, procedures and treatments). Even the best proven interventions must be evaluated continually through research for their safety, effectiveness, efficiency, accessibility and quality. Medical research is subject to ethical standards that promote and ensure respect for all human subjects and protect their health and rights[12].

Clinical Ethics

Ethics in the context of care is called *clinical ethics*. It deals with ethical issues arising especially in the practice of health care providers. These issues can affect patients or their families, caregivers and managers of an establishment. In addition, tensions may be in the relations between the actors, because of their different approaches or differences in their perception of the situations involved, and future complicate problem resolution[13].

Clinical ethics may be defined as a discipline or methodology for considering the ethical implications of medical technologies, policies, and treatments, with special attention to determining what ought to be done (or not done) in the delivery of health care[14].

Other issues have to do with technology and the quality of life. Indeed, we can ask ourselves if a technological means should be used every time when it is physically possible to use it and who should decide to use it. Another cause of tension is the pressure on the health system by increasing demands and resources are the same, limited.

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[11] J. Pierce, G. Randels, *Contemporary Bioethics. A Reader with Cases*, Oxford University Press, New York, 2010, p. 487.

[12] World Medical Association, *Declaration of Helsinki*, 2013, available at http://www.wma.net/en/30publications/10policies/b3/, last accessed on the 12.12.2015.

[13] Cf. Définition de l'éthique clinique, available at https://www.chusj.org/fr/Professionnels-de-la-sante/Unite-d-ethique-clinique/Definition-de-l-ethique-clinique, last accessed on the 12.12.2015.

[14] University of Washington School of Medicine, *Law and Medical Ethics: Ethical Topic in Medicine*, available at https://depts.washington.edu/bioethx/topics/law.html, last accessed on the 12.12.2015.

The diversity of values encountered within society can be another source of misunderstandings and conflicts. The interdisciplinary approach of clinical ethics can address diversity issues through several angles.

Clinical ethics affects all decisions, uncertainties, values conflict and dilemmas that doctors, health professionals and social services are facing to. The purpose of clinical ethics is to improve the quality of care provided to the patient and the quality of the work of clinical staff through an interdisciplinary approach by identifying, analyzing and proposing possible solutions for ethical problems in practice clinical.

Medical Ethics

Medical ethics represents actually a code of practice by which doctors govern their professional behavior[15]. As well as the avoidance of *malpractice*, *medical ethics* is concerned with the many moral questions and dilemmas that have arisen in consequence of medical advances – questions such as the rightness of prolonging life by extraordinary means, choices in allocating limited resources, decisions about organ transplantation, the propriety of psychosurgery, how far research on fetuses is justified, how trials of new drugs should be conducted, whether the diagnosis of genetic defects in embryos is always justified and how far genetic engineering may ethically proceed.

Medical ethics is closely related, but not identical to, *bioethics* (biomedical ethics). Whereas *medical ethics* focuses primarily on issues arising out of the practice of medicine, *bioethics* is a very broad subject that is concerned with the moral issues raised by developments in the biological sciences more generally[16]. Medical ethics focused primarily on issues arising out of the physician – patient relationship. The ancient Hippocratic literature (which includes but is not limited to the Hippocratic Oath) enjoins doctors to use their knowledge and powers to benefit the sick, to heal and not to harm, to preserve life, and to keep in the strictest confidence information that ought not to be spread about (though precisely what must be kept confidential is not detailed)[17]. These basic values and principles remain an essential part of contemporary bioethics. However, after the Second World War it became clear that the old medical ethics was not sufficient to meet contemporary challenges.

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[15] *Collins Dictionary of Medicine* © Robert M. Youngson 2004, 2005, available at http://medical-dictionary.thefreedictionary.com/medical+ethics, last accessed on the 13.12.2015.

[16] World Medical Association, *Medical Ethics Manual*, 3rd Edition, 2015, p. 9-10, available at http://www.wma.net/en/30publications/30ethicsmanual/pdf/ethics_manual_en.pdf, last accessed on the 13.12.2015.

[17] B. Steinbock, *The Oxford Handbook of Bioethics*, Oxford University Press, 2007, p. 2.

Ethical Questions

Trying to understand and analyze this particular case, many questions raised up.

1. The first set of questions is related to the forced sterilization practice: **What** is **wrong** and **why**? The practice? Physician's decision to proceed with forced sterilization? Their intention or purpose to regulate some social issues? Or the consequences of these practices? All they did is wrong. The forced sterilization is bad and wrong, because it produces bad medical consequences for this woman life. Their decision to put in act these practices is wrong, because this is not something normal and specific to the doctor-patient relationship. The patient needs to trust physicians and they go to the doctor because they are professional and they work for the good of their patients, and not for other reasons. If they thought that they could regulate some social issues doing the forced sterilization of their patients, this is also wrong. Why? Because regulating social issues is not a physician job. Always in the history we had social problems, but never had we thought that a doctor profession is to find solutions and regulate social problems. The consequences are huge: patients lose confidence in doctors and we are afraid that doctors can put in act their personal opinions on social and cultural problems in the society.

2. What are the **ethical principles** violated by these physicians?

In their current medical practice, all physicians need to respect the following ethics principles: autonomy, beneficence, non-maleficence, and justice. Definitions of these principles and the rules that are set up in the following table:

Principles	Definitions	Rules
Respect of the autonomy	Each individual: • Is unique and free; • Has the right and capacity to decide; • Has value and dignity; • Has the right to informed consent. • Respect the choices and personal positions and decisions of patients. Giving weight to the opinions	• Truth Telling • Respect for private life • Protect the confidentiality • Get the Informed Consent

Principles	Definitions	Rules
	and choices of autonomous persons; refraining to obstruct their actions unless, obviously, these actions cause harm to others.	
Beneficence	The obligation to act for the well-being of others.	• Prevent harm • Remove harm • Make and promote good.
Non-maleficence	The obligation not to harm others.	• Avoid harm.
Justice (proportionality or equity, non-exploitation/non-discrimination)	The obligation to treat equally cases, in the same way (formal justice principle).	• For every person : o Its legal part o According to its needs o According to its efforts o According to its contribution o According to its merit.

In our case, **all principles of medical ethics are violated by doctors:** the autonomy, because they did not respect patient's wishes; beneficence, because they did not act for the good of the patient; non-maleficence, because they did harm for patient life; and justice, because they discriminate the patient, they did not treat her equally, in the same way like other patients. Also, we wonder about the Informed Consent form.

Why Informed Consent?

Because it is the key to respecting autonomy and provides a reasonable assurance that the subject or the patient has not been deceived or coerced[18]. Council for International Organizations of Medical Sciences (CIOMS) defines the Informed Consent as a decision to participate in research, taken by a competent individual who has received: the necessary information, who has adequately understood the information and who, after considering the information, has arrived at a decision without having been subjected to coercion, undue influence or inducement, or intimidation[19].

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[18] O. O'Neil, *Some limits of Inform Consent*, in "Journal of Medical Ethics", 2003:29:4-7.

[19] Council for International Organizations of Medical Sciences (CIOMS), *International Ethical Guidelines for Biomedical Research Involving Human Subjects*, 2002, p. 4.

In fact, Informed Consent Guidelines from the International Federation of Gynecology and Obstetrics assert that “informed consent is not a signature but a process of communication and interaction,” and that the “difficult and time-consuming” nature of obtaining informed consent does not “absolve physicians caring for women from pursuing … informed consent”[20].

The World Health Organization has also indicated that “[a]ll clients should be carefully counselled about the intended permanence of sterilization and the availability of alternative, long-term, highly effective methods”[21].

A simply signature is not enough. Doctors need to provide with information about the surgery and they need to check if patients understood this information.

3. **Who** decided such a practices?

If thousands of Roma women have undergone to forced sterilization, the question is who has taken such a decision? The physician him or herself? Or it was the responsible of the unit or department? It could be a public policy? If we take into account the current legal regulations in European countries, it is quite impossible to imagine another professional figure that can, in a way, to interfere between the doctor and the patient. And even if someone tries to ask to the physician to do such a thing, the physician must to respect legal norms and the professional deontology. But nevertheless, doctors are not always sufficiently protected by some influence from the society and they could be used or coerced, at least hypothetically, to carry out practices that are contrary to their professional and personal ethics.

4. Could doctors **refuse** to proceed with forced sterilization, if this kind of practices is current in some medical units?

Doctors can always refuse any practice which conflicts with their conscience, their morals or their religions. Because on the 7th October 2010, Parliamentary Assembly of the European Council, adopted a Resolution (R 1763) which regulate **the right to conscientious objection** in lawful medical care[22]. Conscientious clause is considered to be the possibility given to a physician through whom he or she can avoid to apply some rules of the law, of his medical profession. Norms or practices can be, sometimes, in conflict with moral or ethical values of the physician.

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[20] International Federation of Gynecology and Obstetrics (FIGO), Ethical Issues in Obstetrics and Gynecology (2006), available at www.figo.org/docs/Ethics%20Guidelines%20-%20English%20 version%202006%20-2009.pdf.

[21] World Health Organization, Medical Eligibility Criteria for Contraceptive Use 151 (3rd Ed., 2004), available at http://www.who.int/reproductive-health/ publications/mec/mec.pdf.

[22] European Council, The right to conscientious objection in lawful medical care, Resolution 1763 (2010), available at http://assembly.coe.int/nw/xml/News/FeaturesManager-View-EN.asp?ID=950, last accessed on the 12.12.2015.

> No person, hospital or institution shall be coerced, held liable or discriminated against in any manner because of a refusal to perform, accommodate, assist or submit to an abortion, the performance of a human miscarriage, or euthanasia or any act which could cause the death of a human fetus or embryo, for any reason.

The reasons for conscientious objection are a "deep conviction" in relation to ethical or moral values, often but not mandatory religious. It is an exercise of the doctor freedom of conscience, which is part of human rights.

Conclusion

What we learn from this case? Forced sterilization is a serious abuse that has gone unacknowledged and underreported for over a century. For patients and for us, generally speaking, is right to determine our own medical care and our destiny. Patients of the world need and deserve doctors who will respect their rights as well as their health. And we must not forget that all doctors will be, a day, also patients. And we finish with a Romanian saying: "Don't do to others what you don't like to be done to you".

Relevant Human Rights Framework

1. *Convention on the Elimination of All Forms of Discrimination against Women* (1982)

Article 10 (h) – States shall ensure "[a]ccess to specific educational information to help ensure the health and well-being of families, including information and advice on family planning."

Article 12 – States shall ensure "access to health care services, including those related to family planning."

Article 16 (1) (e) – Women have the right "to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights."

General Recommendation No. 21 - "In order to make an informed decision about safe and reliable contraceptive measures, women must have information about contraceptive measures and their use, and guaranteed access to sex education and family planning services."

General Recommendation No. 24 - "Acceptable [health-care] services are those that are delivered in a way that ensures that a woman gives her fully informed consent. … States parties should … ensure timely access to the range of services that are related to family planning … including information and counseling on all methods of family planning."

2. *European Convention on Human Rights and Biomedicine* (1997)

[**Article 5**]: "An intervention in the health field may only be carried out after the person concerned has given free and informed consent to it. This person shall beforehand be given appropriate information as to the purpose and nature of the intervention as well as on its consequences and risks. The person concerned may freely withdraw consent at any time."

[**Article 10**]: "Everyone has the right to respect for private life in relation to information about his or her health. Everyone is entitled to know any information collected about his or her health."

Other International Human Rights Law

International Covenant on Civil and Political Rights (1996)
[Article 19 (2)] - "Everyone shall have the right to freedom of expression [including the] freedom to seek, receive and impart information".

Convention on the Rights of the Child (1989)
[Article 24 (2) (f)]- States shall "develop preventative health care, guidance for parents and family planning education and services."

Committee on Economic, Social and Cultural Rights, General Comment No. 14 - "The Committee interprets the right to health [as extending] to the underlying determinants of health, such as … access to health-related education and information, including on sexual and reproductive health." [Paragraph 11]

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INTERVIURI

STUDIA UBB BIOETHICA, LX, 2, 2015 (p. 117-119)
(RECOMMENDED CITATION)

MASTER'S DEGREE PROGRAM IN BIOETICS

Interview with Ioan Alexandru Beldean,
MA in Bioethics at Case Western Reserve University, Cleveland, USA,
done by Maria Aluaș

Question 1: "From Orthodox Theology to Bioethics in American academic context: How come"?

The interest in the startling field of bioethics came as a natural extension of my previous studies in Moral Theology. After graduating the BBU MA Program in Bioethics, I received the opportunity to enroll in a slightly different program of study in Bioethics, at the Case Western Reserve University, in Cleveland, USA. This academic endeavor was supported by the Fogarty International Foundation, which as I had to find later on, was offering students from all around the world an opportunity to have a hands on approach of International, American Bioethics, through various MA programs.

Question 2: "What was the structure of your MA Program"?

What made the experience truly outstanding, is the professional training offered in just two semesters of study. The design of the program was tailored on market values and needs. Structurally speaking, the training Program had two parts. The first was following a Master's Degree in Bioethics, and the second was considering a research project meant to apply our recently gained expertise and facilitate our re-entry to the Romanian Research Ethics field.

For the Academic part, the two semesters were constructed as follows.

In the fall we studied Fundaments in Bioethics, Ethics - Law and Health Research and the ground stone of any ethical analysis experience, Clinical Rotation. In Foundations, we learned the basics in the field, tackling topics like Approaches to Bioethics, Reproductive Ethics, Pediatrics Ethics and Death and Dying. The Research Ethics class was an introductory course in research design and in the major controversies in the field, meant to acquaint us with the particularities of the US law corpus, the interaction between these areas of study, and the general Ethical, Legal, and Social Implications of Bioethics. I would like to stress the importance of the last class, Clinical Rotation. While many theories and action plans may be apprehended in a theoretical class, the practical experience associated with working as a clinical ethicist can only be developed through intense work in a clinical setting. After having experienced more than 80 hours of clinical rotation, which included shadowing various professionals, attending ethical analysis committee meetings, obtaining critical IRB exposure, observing transplant committee sessions, all culminated with weekly meetings with public and private policy makers, physicians and ethicists to analyze and develop the knowledge and understanding of all the elements involved in the above mentioned practices. By the start of the second semester, almost every and any novel activity seemed natural and equally important in grasping the essentials needed by a bioethicist.

In the Spring term, our focus of study was directed towards the subject of Research Ethics in its entirety. As we continued our Foundations classes, we studied Public Health Ethics, Neuroethics, Stem Cell Ethics and Research Ethics. Another class that continued the global understanding and integration of a researcher was International Health Research Ethics, which analyzed multicultural aspects within the field, such as national and international research guidelines and regulations, socially adaptive behavior, cultural context of research and international research ethics case discussions. And just as in the first semester, the applied knowledge came through a Research Practicum class, designed to allow us to conduct research or help with on-going research projects. My personal interest in this training period was genetic research regulations and the secondary use of genetic samples in research. I analyzed regulations regarding medical waste management within the 50 states and the use and regulation of bio banks and virtual biorepositories. After spending a semester on this topic, I was able to offer a properly researched ethical analysis of the phenomena and possible solutions to the problems discovered. This was not only an abstract activity, but it produced information for publishing several articles in the field. Besides this individual research activity, I accumulated more than 30 hours of behavioral IRB experience, in both reviewing protocols and handling communications and resolving the inherent rising of ethical issues.

Question 3: "Did this Program offer additional training for Fogarty students"?

On top of all the above mentioned courses, as international students we had four other classes which were meant to accelerate our knowledge in research ethics, both American and Romanian, in which we explored local and foreign topics, research procedures, and trainings in protocol writing, grant application procedures, conducting research as Principal Investigator, preparing manuscripts, coordinating Institutional Review Boards and managing all the conflicting situations that might arise during a research project or while managing an ethical oversight system. This was part of a theoretical and practical training offered to prepare the integration in our native research ethics system.

Question 4: “What are the practical consequences of this program for you”?

Being enrolled in the *Research Ethics Track* proved to be an inspired decision from our advisor, Professor Sana Loue. It allowed us not only to learn bioethics as a profession, but also gain the know-how and professional expertise to conduct research ethics analysis and manage projects in this field.

As a consequence, my re-entry project consists of conducting a study called “A Study on Research Ethics in Babeș-Bolyai University, based on published papers, interviewed researchers and institutional orientation”. It is aimed at understanding the complexity of the local situation regarding the ethical oversight of human subject research. Based on this project, along with the Bioethics Center of BBU and the administrative support of BBU, we plan to develop instruments and actions to address the identified needs in this internationally relevant field.

Another accomplishment would be the opportunity to apply and advance my knowledge through a position of Research Associate at the Ohio State University, where I support the efforts of teaching Research Ethics under the management and guidance of Dr. Ryan Nash, Director of the Center for Bioethics and Medical Humanities, in Columbus, Ohio.

STUDIA UBB BIOETHICA, LX, 2, 2015 (p. 121-123)
(RECOMMENDED CITATION)

RECENZIE – BOOK REVIEW

Hans Kung, *La mort heureuse*, trad. Jean-Louis Schegel, Editions du Seuil, Seuil, 2015.

Plasată sub un titlu de-a dreptul incitant pentru cititorul laic, care nu reprezintă însă altceva decât traducerea “mot-à-mot” a cunoscutului termen grecesc “euthanasia”, ultima carte a controversatului Hans Kung expune și dezbate frământările legate de sfârșitul său. Ca orice lucrare în paginile căreia sunt analizate aspecte legate de propria persoană, și acesta ar putea fi încadrată în genul autobiografic[1]. În condițiile în care a publicat deja două volume de memorii și este pe cale să îl publice pe al treilea[2], cititorul s-ar putea întreba ce rost mai are un apendice, o anexă în care se vorbește despre un aspect al biografiei detaliat deja pe larg în paginile altor lucrări.

Lectura motivației și a cărții oferă un răspuns complex la această problemă. Astfel, pe de-o parte este vorba de o chestiune cu valoare universală și de importanță socială, moartea, iar pe de alta despre conturarea unor idei ce definesc modul de a gândi al teologului. Întregul demers pornește de la o întrebare fundamentală: *“există o moarte fericită?”* și de la intenția autorului, suferind de maladia Parkinson[3], de a-și încheia traseul pământesc cu ajutorul tehnicii medicale atunci când sănătatea lui va fi foarte puternic zdruncinată de aceasta.

În cadrul celor opt capitole și al interviului ce se regăsesc în paginile lucrării, Hans Kung dezbate, analizează, propune soluții și încearcă să își argumenteze punctul de vedere cu privire la dorința de a-și grăbi moartea atunci când va constata o degradare puternică a propriei stări de sănătate. În cadrul primei părți ale lucrări, constituită de către scurta introducere, discuția cu Anne Weill, reporter la o televiziune germană, realizat în luna noiembrie a anului 2013 (pp. 23-35), și câteva scrisori ce conțin reacțiile cititorilor memoriilor autorului la decizia sa, acesta arată ce a determinat adoptarea unei decizii atât de radicale. El însuși ține să mărturisească faptul că, la baza convingerii sale stau două evenimente personale, respectiv sfârșitul trist al fratelui său, care a suferit în ultima parte a vieții de o tumoare cerebrală (p. 49) și cel al lui Walter Jens, care i-a fost coleg

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[1] De altfel, spațiul catolic, din care Kung încă se revendică, cunoaște începând cu secolul XX o amplificare și diversificare a acestui gen. Însă, în comparație cu unele opere memorialistice sau cu însemnările personale ale unor oameni precum papa Ioan Paul al II-lea (Papa Ioan Paul II, *În mâinile Domnului. Însemnări personale (1962-2003),* trad. Mariana Băluță-Skultéty, Constantin Geambașu, colecția. “Memorii – Jurnale”, Editura Humanitas, București, 2015), însemnările lui Kung se particularizează în cadrul genului, ele promovând idei ce nu pot fi circumscrise tiparului clasic.

[2] Hans Kung, *My Struggle for Freedom. Memoirs,* Eerdmans, Grand Rapids, Michigan, 2003 (Novalis, Ottawa 2003; Continuum, London 2003); Idem, *Disputed Truth. Memoirs*, vol. II, Continuum Publishing House, London, 2008.

[3] După cum însuși mărturisește (p. 17).

și prieten apropiat: „*L'ars moriendi* sau arta de a muri mă preocupă de când fratele meu George a suferit, vreme de mai multe luni, de o tumoare cerebrală nevindecabilă, înainte de a muri asfixiat de apa din plămânii săi. Această idee s-a impus în mod special în mintea mea după ce, prin anul 2005, dragul meu coleg și prieten Walter Jens a fost pierdut în demența lui, până la moartea-i survenită în 2013. Aceste lucruri trăite mi-au adus în minte convingerea mea că nu așa vreau să mor” (p. 16)[4].

Lecturând aceste rânduri, cititorul ar putea fi tentat să creadă că frica de o moarte dezonorantă, nedemnă, este cea care îl determină pe teologul german să-și dorească o moarte provocată și asistată. Interviul relevă însă un motiv mult mai profund al alegerii sale: “Anne Will: Dar de ce doriți să vă sfârșiți viața în cazul în care resimțiți indiciile uni început de demență?

Hans Kong: „Pentru că nu cred că viața pământească este totul. Acest lucru ține, natural, de convingerile mele de credincios: nu cred, în concluzie, că voi muri pentru a intra în neant” (p. 25). Pentru prima dată, în cadrul discuțiilor cu privire la o problemă sensibilă a bioeticii, un teolog, ce-i drept contestat, folosește premisele care sunt utilizate de obicei de către exponenții diferitelor confesiuni creștine[5] în cadrul discuțiilor privitoare la chestiuni precum eutanasia. Concluzia la care ajunge este însă una radical diferită de cea a teologilor. Dacă în viziunea acestora, faptul că există viața veșnică, corelat cu calitatea lui Dumnezeu de a fi unicul dătător de viață, îl obligă pe creștin să nu își sfârșească singur viața din propria inițiativă nici într-o situație, în viziunea lui Kung, tocmai existența unei vieți de dincolo constituie motivul dorinței de a grăbi sfârșitul celei de aici, pentru a reuși să o înceapă mai repede pe aceea.

În capitolele următoare, el încearcă să își expună pe larg crezurile și să își argumenteze punctul de vedere pornind de la anumite norme ale eticii medicale (pp. 57-

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[4] În alt loc, dorind să accentueze cât de mult a fost marcat de aceste experiențe personale, el spune: “Evenimentele personale pot să marcheze mai mult decât toate felurile de gânduri, oricât de profunde ar fi ele” (p. 49).

[5] Căci, în privința problemelor de bioetică, Catolicismul, Ortodoxia și Protestantismul sunt, cu excepția câtorva nuanțe, de aceeași părere. Pentru o viziune creștină asupra eutanasiei, dar și asupra altor probleme importante de bioetică, a se vedea, de exemplu: Pavel Chirilă, Mircea Gelu Buta, Andreea Băndoiu, „Argumente teologice împotriva eutanasiei”, în *Studia Universitatis Babeş-Bolyai – Series Theologia Orthodoxa,* anul LVII, nr. 2, Decembrie, Cluj-Napoca, 2012, pp. 57-64; Mircea Gelu Buta, „Bioetica creștină într-o lume post-creștină”, în *Studia Universitatis Babeş-Bolyai – Series Theologia Orthodoxa,* anul LVII, nr. 2, Decembrie, Cluj-Napoca, 2012, pp. 51-56; H. Tristam Enghelhardt jr., *Fundamentele bioeticii creștine – perspectiva ortodoxă,* trad. Mihai Neamțu, Cezar Login, Ioan Ică jr., Editura Deisis, Sibiu, 2005; Idem, *Curs de bioetică,* Editura Renașterea, Cluj-Napoca, 2005; Aurel Radu, „Temeiuri morale creștine pentru apărarea vieții”, în rev. *Studii Teologice,* anul XXXVI, nr. 9-10, București, 1984, pp. 650- 653; Georgios Mantzaridis, *Morala creștină,* trad. Constantin Coman, Editura Bizantină, București, 2006; Jean-Claude Larchet, *Dumnezeu nu vrea suferința omului,* trad. Manuela Bojin, Editura Deisis, București, 2008; Ioan Ică jr, Germano Marani, *Gândirea socială a Bisericii. Fundamente – documente – analize – perspective,* col. „Civitas christiana”*,* Editura Deisis, Sibiu, 2002. Pentru o perspectivă mai amplă, ce analizează și anumite aspecte sociologice și psihologice cu privire la fenomen, a se vedea și: Iulia-Maria Puie, “Atitudini și comportamente cu privire la eutanasie. Perspectiva psihologică și perspectiva socială”, în Doru Sinaci, Emil Arbonie, coord., *Administrație românească arădeană Studii și comunicări din Banat – Crișana 95 de ani,* vol. VII, col. “Slaviciana”, serie nouă, “Vasile Goldiş” University Press, Arad, 2014, pp. 581-595.

64), de la conceptul de îngrijire paliativă (pp 65-80)[6], ideea de responsabilitate în raport cu sinele în apropierea morții (pp. 91-100), schimbarea de paradigmă în ceea ce privește raportarea la viața umană (pp. 101-106), care, în viziunea lui, aduce cu sine *"posibilitatea de a zice nu vieții veșnice"* (p. 106) și alte aspecte similare. Înspre finalul expunerii, el anexează și textul scrisorii ce i-a fost adresată de către un prieten din Orientul Apropiat, ce sintetizează concepția creștină, optimistă într-un fel, cu privire la suferința ce preceda sfârșitul existenței pământești: "Te rog, în genunchi, chiar dacă ti-au apărut de câțiva ani semnele unei demențe precoce, rămâi cu noi; suferința ta va deveni binecuvântare și har pentru noi, la fel cum moartea teribil de dureroasă a lui Iisus a devenit mântuitoare pentru noi. În această mântuire este de asemenea inclusă prin esență acceptarea suferinței. Dumnezeul Înviat să-ți redea responsabilitatea vieții tale într-o dragoste iertătoare" (p. 120). Argumentele lui Hans Kung, inconsecvente și inconsistente pe alocuri, sunt totuși interesante și reprezintă fundamentele unei convingeri atipice, dar profunde. Faptul că, deși starea lui s-a degradat destul de mult în ultima parte a anului trecut, aceasta nu l-a determinat să adopte drastica măsură propusă, a constituit pentru unii un semn că teologul a revenit asupra concepțiilor sale (pp. 129-130).

Cu toate acestea, cel puțin din punct de vedere teoretic, el nu s-a dezis de crezurile enunțate în paginile memoriilor și dezvoltate aici, ci dimpotrivă, încearcă să argumenteze unor personalități cu autoritate în Biserica Apuseană, între care se numără și papa Francisc, justețea convingerilor lui.

Efervescent și protestatar, atipic și locvace, Hans Kung și-a creat în cea de-a doua parte a vieții sale imaginea unui teolog valoros ce dorește să se individualizeze și să se remarce prin convingerile sale revoluționare. Contestat de unii, aplaudat de alții, el rămâne, totuși o voce importantă a teologiei. Opiniile lui, fie ele de teologie biblică, doctrină sau bioetică, se bucură de o oarecare receptare și nu pot fi ignorate de către specialiști. Între ele, cea privitoare la eutanasie, argumentată cu multă pasiune întrucât frizează însăși evenimentul propriului său sfârșit, a suscitat interesul mediilor științifice și credem că îl va suscita în continuare. Fie că vor subscrie sau nu convingerilor lui, e important ca cercetătorii să le cunoască și să le analizeze, ele putând oferi informații utile de natură psihologică, istorică sau sociologică cu privire la fenomenul morții și la evenimentele care l-au marcat pe autor.

IULIU-MARIUS MORARIU

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[6] A se vedea: Adriana Căruntu, *Îngrijirea paliativă – importanța consilierii furnizorilor de servicii medicale paliative,* Editura Cuvântul Vieții, București, 2012; Despina Maria Baghiu, *Îngrijiri paliative la copil,* Târgu Mureş University Press, Târgu Mureş, 2004; Marie Fallon, Bill O'Neill, eds., *ABC of palliative care,* BMJ Books, London, 1998; ***, *The Human Condition Between Suffering and God's Love. Disease Therapy and Paliative Care. International Symposium Faculty of Orthodox Theology Alba Iulia, 4-6 May 2012 / Condiția umană între suferință și iubirea lui Dumnezeu - terapia bolii și îngrijirile paliative. Referatele Simpozionului Teologic Internațional organizat de Facultatea de Teologie Ortodoxă din cadrul Universității "1 Decembrie 1918" Alba Iulia, 4-6 mai 2012,* Editura Reîntregirea, Alba-Iulia, 2012; Daniela Moșoiu, coord., *ABC-ul îngrijirii paliative,* Editura Lux Libris, Braşov, 1999, pentru mai multe informații cu privire la acest concept și implicațiile lui.

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